
Final Report
To The Office of Planning and Evaluation
Health Resources and Services Administration

On the Project Entitled

**TOOLS FOR MONITORING
CULTURAL COMPETENCE
IN HEALTH CARE**

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I. OVERVIEW

A. BACKGROUND

The impact of cultural and linguistic diversity on the delivery of health care to minority populations in the United States is a relatively new field of study. It has emerged in response to increasing concerns of minority groups that the growing consolidation of health care services into managed care systems will lead to a "one size fits all" approach to medicine. In California, the state government responded to this concern by establishing cultural competency guidelines for Medi-Cal health plan contractors.

In attempting to develop specific tools to monitor providers' cultural competence, one must address the question "What is culturally competent health care?" Specifically, how does culturally competent care differ from the standard practice of medicine provided to patients from the (usually English speaking Caucasian) ethnic majority? Prior studies have focused on the use of interpreters, and the translation of health promotion materials as structural evidence of cultural competence. Little has been done in these earlier studies to investigate the interaction between the physician and culturally or linguistically diverse patients. There has been particularly little investigation of cultural competence in the context of a managed care systems (cf. the literature review in Section I.D. below for more details regarding prior studies). Phase I of the project funded by the Health Resources and Services Administration has as its principal goal the development of tools which can be used to assess the cultural competence of primary care providers practicing within managed care systems.

This project is being administered by the Latino Coalition for a Healthy California. The Latino Coalition has played a leadership role in the development of cultural competency standards for managed care plans in California. The Latino Coalition was instrumental in the development of "A Cultural Index of Accessibility to Care," language and cultural competence guidelines for managed care providers serving the Medi-Cal population. California's Department of Health Services is requiring providers in its Medi-Cal/Managed Care program to implement a modified version of the Cultural Index. Since this undertaking, the Latino Coalition has sought to further delineate a series of guidelines and/or instrumentalities which can be used both by managed care systems and by governmental agencies to monitor the former's sensitivity to the needs of enrollees drawn from distinct cultural and linguistic minority groups. These guidelines have implications for all stages of clinical care processes, ranging from the diagnosis and treatment of acute problems through counseling regarding making recommended healthy lifestyle changes. As an initial step, the project team recognized the need to clarify the factors which distinguish culturally competent primary care from care which is culturally incompetent.

It is helpful in this context to distinguish the concepts of providers' cultural competence from provider cultural sensitivity. By "cultural competence", we mean the level of knowledge based skills required to provide effective clinical care to patients from a particular ethnic or racial group. By "cultural sensitivity" we mean a psychological propensity to adjust one's practice styles to the needs of different ethnic or racial groups. We do not assume that providers who possess one of these qualities will necessarily possess both. One example is that physicians from one ethnic group may be competent to treat patients from their own ethnic group while lacking cultural sensitivity needed to address the needs of patients from other ethnic groups.

This project is limited to the study of cultural competence due to the great difficulty in measuring cultural sensitivity.

There is a growing literature which describes the varied health outcomes experienced by patients with different socio-economic backgrounds (cf. below, Section 4.D.). However, little has been written about the extent to which cultural and language differences between the health provider and patient impact these outcomes. To begin to develop tools which can be used in exploring the health status implications of sociocultural differences between patients and providers, the project team examined the degree to which accepted standards of primary health care need to be adapted to address the needs of patients from diverse cultural and linguistic backgrounds.

B. METHODOLOGY

To clarify the dimensions of culturally competent health care practices, the project convened two expert panels. These expert panels were composed of primary care physicians and other health care professionals drawn from among the clinical and administrative staffs of two of the most respected minority owned and operated health maintenance organizations in California. One is the Chinese Community Health Plan (CCHP). The CCHP is an 11,000 member IPA located in San Francisco's Chinatown. The other plan is the Community Health Group of San Diego County (CHG). The CHG is a Latino owned IPA with 35,000 members which serves a primarily Latino membership. The panelists from both groups are all minority physicians. They were selected by the Medical Directors of each Health Plan for their knowledge of and sensitivity to the health care needs of the respective minority populations they serve.

To focus their deliberations, all panelists completed a project designed provider awareness survey prior to their participation in the panels. The questions asked in the survey were designed to prompt the participants to examine the appropriateness of diagnostic and treatment patterns developed to care for patients drawn from the (English-speaking Caucasian) ethnic majority when used in the care of patients drawn from non-English speaking ethnic minority communities. The project team deliberated on whether to address this question by approaching the physician panels of each health plan with general questions relating to primary care or have them focus on how they care for certain common target conditions. The panels decided to follow the latter approach. Panel members felt that clinically important differences between optimal approaches to English-speaking patients who were members of ethnic majorities and non-English-speaking patients drawn from ethnic minority communities could best be identified by examining specific target conditions. The panels identified three chronic health conditions as strong indices of care providers' wider cultural competence: asthma; diabetes; and hypertension.

These conditions were chosen by the Medical Directors because they were among the conditions for which their Plans' primary care physicians found treatment adherence problems among Chinese and Latino enrollees to be most likely. By using these conditions as points of departure, they hoped to elicit indices of the cultural competence of physician practices which would be generally applicable across the most common conditions encountered in primary health

care settings. Background materials on each condition were made available to the panelists. Panelists were asked to address the role of cultural and linguistic factors in achieving adherence to the accepted standards of care for these conditions.

Specifically, each panelist was first asked to evaluate the impact of cultural and linguistic factors in implementing the National Institutes of Health (NIH) guidelines for chronic severe asthma management in adults and children. The panelists then conducted a similar evaluation of the impact on implementation of the standards for basic (minimum) care for people with Diabetes Mellitus. Finally, the panelists were asked to conduct a similar analysis of barriers to implementation of the NIH guidelines for the diagnosis and treatment of hypertension. This latter evaluation was based on a synopsis of applicable NIH Guidelines which was provided to the panelists. (The target condition guidelines which were circulated to the panelists are readily available on request). Project staff provided panelists with additional information summarizing recent research on severe uncontrolled hypertension in an inner-city minority population. That research found that almost all cases of uncontrolled hypertension had been previously diagnosed and treated (i.e., the failure to control the hypertension resulted from inadequacies in patient education, follow-up, and from the resulting inadequate patient adherence to prescribed regimens).

During the first panel session, the physician experts had the opportunity to discuss the optimal care experience for their minority patients. During the second panel session they were asked to review a draft patient satisfaction survey instrument prepared for both panels in terms of its clarity, its understandability, and its ability to capture the subtleties of this optimal care experience. The insights from the first panel's discussion of the optimal care experience were incorporated into a revised questionnaire for presentation at the second panel. The second Chinese panel was informed of the revisions to the written survey made by the second Latino panel. Their final draft reflected several revisions to the Latino version. Yet these revisions were overall consistent with the intent and substance of the Latino panel's deliberations.

The survey's final draft with these revisions was submitted to external expert consultants for their review. These experts included: Eliseo Perez Stable, M.D. of the University of California San Francisco School of Medicine; Ka Kit Hui, M.D. of the University of California Los Angeles School of Medicine; Arthur Chen, M.D. of the Asian Health Center; and Howard Barkan, Dr.P.H., independent consultant. While these individuals acknowledged that the content of culturally competent care for Latino and Chinese patients differed in several respects, they concurred with the physician panelists that a single instrument, when translated into the appropriate languages and presented in the appropriate ways, could be used to survey members of both health plans regarding their satisfaction with the care they had received. This led the Health Plan Medical Directors and project researchers to conclude that a common patient survey instrument could be presented to both Chinese and Latino patient panels for their completion and comment.

The physician panels also had separate discussions about using ethnic identifiers to describe the cultural and linguistic characteristics of patient populations. The project team prepared background materials for these discussions. Copies of current federal and state forms used to elicit individuals' ethnic and racial backgrounds were distributed to panelists for review. These were the Medi-Cal (i.e., California's Title XIX program) application forms; and the OMB

Community Health Center User's Survey.

Interviews were also conducted with individual panel members and outside consultants. Materials resulting from panel discussions were amended where appropriate to reflect the results of the individual interviews. All panel meetings used a semi-structured format. The content validity of the resulting instruments (which are presented and discussed below) could be evaluated in a larger commercial health setting by using similar Delphi techniques or other forms of structured group process to explore the topics discussed by the physician panels with other providers experienced in caring for members of these and other non-English speaking ethnic communities.

The patient panels were conducted in the form of focus groups with 8 to 10 health plan members attending each of the two panels. The panelists had to meet the following criteria for selection:

- a) **Non- or Limited-English Speaking.** This was important to test the appropriateness of using the model patient survey instrument on a non- or limited English speaking population.
- b) **Suffering from Hypertension.** The choice of health plan members with this condition was designed to capture the issues culturally and linguistically diverse patients with a chronic health condition face in receiving care. Our review of the literature highlighted the heightened compliance problems cross-cultural communication presents for such individuals with chronic illnesses in both a fee for service and a managed care setting.
- c) **Living in neighborhoods with high concentrations of recent immigrant populations.** This affiliation was important to ensure that panel members reflected a strong ethnic cultural identity and tended to use languages other than English in their everyday lives. The San Diego panelists were selected from the patients of a CHG health plan provider located in the barrio adjacent to the Mexican border (i.e., the San Ysidro Health Clinic). The San Francisco panelists were selected from among those residing in the city's Chinatown area.

Prior to attending the focus groups, each panelist participated in a phone interview using the draft patient satisfaction survey instruments developed from the Latino and Chinese physician panels. Each interview lasted approximately 20 minutes, and was conducted by a trained bilingual interviewer.

Each of the two focus groups also was conducted in the native language of the participants. For the Latino patient group the session was conducted in Spanish by Dr. Miguel Tirado, the Project's Principal Investigator. For the Chinese panel the session was conducted jointly by Dr. Tirado and a member of the Chinese Health Plan's member services staff who spoke Cantonese. Each session began with the acknowledgement that the meeting's purpose was to evaluate and critique the survey and not the health plan or its providers. This proved to be difficult for the participants to remember, resulting in constant reminders throughout the sessions of the purpose of the focus groups. The panelists were asked to focus on evaluating each of the

survey questions in terms of their clarity of understanding and their usefulness in eliciting information relevant to the patients' care. This also led them to elaborate on the elements they deemed essential to caring for patients with their cultural and linguistic backgrounds.

LATINO PATIENT PANEL

The Latino panel of health plan members placed great emphasis on the interpersonal rapport between provider and patient as a key element of successful health care. They stressed the need for providers to attend first to establishing an emotional rapport with the patient. An essential element of this was the provider's ability to put the patient at ease. Two methods they suggested to achieve this were the appropriate use of physical touching and personally oriented verbal cues to calm the patient so that they could hear the information the provider had to offer them. The panel members described an example of the use of touching as placing one's hand on a patient's shoulder or arm as a sign of reassurance. The verbal cues were those that encouraged the patient to relate to some dimension of the provider's personal experience or background thereby encouraging a personal connection of the patient with the provider.

The Latino panelists shared that the greatest fear many of them had of their doctor was that he or she would refuse to continue treating them in the event the doctor learned they were seeking medical advice or treatment from someone other than them (e.g., an herbalist, folk healer, or other doctor across the border). This fear surfaced most commonly where the panel member was receiving both treatments simultaneously.

Their frustration with providers centered most around a failure to see any swift improvement in their condition resulting in the desire to seek alternative sources of care. They commented on how they resisted slower treatment regimens for their conditions in favor of injections and stronger medications. They also admitted to difficulty in identifying and understanding the medications they were taking. At most they were able to identify one half of their prescribed drugs. They did find it easier to relate the drugs to a specific condition and knew when they were supposed to take them. The extent to which they were able to answer these questions revealed to the panelists how well their providers had helped them understand their treatment.

The patient panelists were asked to comment on the value of pre-enrollment forms which sought to furnish information to doctors prior to their initial visit with them on their patients' specific linguistic and cultural backgrounds. They identified the following pieces of information they thought a health plan and its providers would find useful in accommodating their specific needs:

- 1) **What is your primary language?**
- 2) **With what ethnic group do you identify?**
- 3) **After reading the information sent to you on the health plan benefits do you need more assistance in understanding them?**
- 4) **Questions about their dietary habits, exercise patterns and living conditions.** These help identify the extent to which the new member has assimilated dominant American life style and health related patterns of thought and behavior.

- 5) **Do they regularly rely on family members and friends to make health related decisions for them?** The patient panelists, however, were uncomfortable sharing with their health plan the actual name or names of the people (e.g., friends and family) they confide in regarding matters of their health.

Regarding the format of the patient satisfaction survey, the panelists uniformly expressed their preference for oral patient surveys over written questionnaires. Several admitted a reluctance to fill out the latter in part due to literacy problems. All the Latino panelists felt this survey served as a very valuable vehicle for them to clarify and express their thoughts about their health care. They also saw it as beneficial in helping patients to understand how they can take more responsibility for decisions regarding their health care.

CHINESE PATIENT PANEL

The Chinese Patient Panel was composed of health plan members suffering from hypertension. Each was interviewed over the phone in Cantonese prior to the panel session. Some respondents indicated their preference for the use of Mandarin, Toisan or other Chinese dialects in such interviews. Interviews were conducted after 7 p.m. on weekdays and on weekends. Major difficulties faced by the interviewers in contacting these individuals by phone included the absence of updated phone numbers, and the practice of several to live in communal living situations where many residents shared a common phone number. The actual conduct of phone interviews lasted 20-25 minutes. Twenty five percent of the respondents said that they preferred a written survey because it would have given them more time to ponder their answers to the questions. They also indicated including with the surveys both a dollar bill and a self-addressed envelope also would have encouraged health plan members to return the surveys.

At the health plan's suggestions, the panel session was scheduled to coincide with the Chinese members' practice of coming to Chinatown for shopping on Saturdays. All the panelists were over 40 years of age and spoke little or no English. They were presented with the same patient survey instrument developed in conjunction with the Latino patients in San Diego. In most cases they were comfortable with the survey questions utilized with the Latino patients. However, there were some differences.

The Chinese stressed the importance of a provider understanding the unique attributes of their body's functioning. For example, they referred to the incompatibility of giving Chinese patients orange juice or hot chicken soup when they had a cold. They also alluded to the difficulty non-Chinese providers have in understanding Chinese patients' low threshold for light headedness and its implications for loss of consciousness.

They also expressed different tolerance levels for waiting times. Their interpretation of acuity of an "urgent condition" led them to perceive less favorably the relevant question's two day tolerance threshold for waiting for an interpreter assisted appointment. In contrast, the Latino patients were more accepting of longer waiting periods, and distinguished less between an urgent office visit and an emergency requiring hospital care. The Chinese panelists also appeared to have higher expectations for gaining referrals to specialists.

They expressed special frustration that their health plan did not permit them "in plan" access to traditional Chinese medical practitioners. They also were unhappy with the practice of health plan contracted pharmacists to fill out prescription medication instructions on the bottle in English instead of in Chinese. Finally they stressed more than the Latino patients did the potential for unaddressed differences of opinion between the patient and the principal family members influencing the former's health care decisions. They acknowledged the difficulties this posed for their health care providers in dealing with family members.

The above differences in responses led to minor additions and revisions of the patient survey instrument to reflect the above insights from the Chinese patient interviews and panel discussion. This proved beneficial to the beta test of the Chinese survey. However, it made difficult comparisons of the Latino and Chinese responses to all the shared questions in the patient satisfaction survey.

C. GUIDING QUESTIONS

The instruments developed in the Latino Coalition project are designed to be used in investigating several questions. Answers to these questions are important to governmental agencies regulating health care, to third parties funding health care, to health care organizations concerned with the activities of the clinicians and health plan staff providing care within their settings, and to patients themselves.

- 1) **How do providers in managed care organizations meet the specific needs of limited English speaking enrollees?**
- 2) **How can a managed care organization assess its success in addressing the specific needs of limited English speaking enrollees?**
- 3) **How can individual health care providers within managed care organizations evaluate the extent to which they are providing high quality culturally competent care to limited English speaking patients?**

The first question raises the issue of whether or not a single standardized approach to provider-patient and plan-enrollee interactions in a managed care setting best serves the needs of ethnically diverse limited English speaking enrollees. Answers to this question potentially challenge the "one size fits all" approach to health care in such settings. In addressing the second question, the project has developed a patient survey which managed health plans can use to help assess the degree to which they are meeting the needs of their limited English speaking enrollees. Addressing the third question, the project has developed a self assessment tool which can be used by the providers themselves to assess how prepared they are to meet the needs of their limited English speaking patients. The project explores this issue by providing monitoring tools which can be used to assess cultural competence in any health professional irrespective of their race or ethnicity.

The project team has no illusions that it can answer the above questions related to these issues given the scale of the issues and the limited resources available for this project. Rather, the project's objectives are:

- 1) To frame the issues related to cultural competence in a manner understandable to both providers and regulators; and
- 2) To design and pretest tools for assessing cultural competence in health care which can be used to begin to address the above questions.

D. REVIEW OF THE LITERATURE

Cross cultural research has been dominated by studies in the field of psychology, with primary attention to its implications for the delivery of mental health services. Much less scholarly attention has been devoted to the role cultural beliefs and cross cultural communication play in the delivery of primary medical care. Even less attention has been given to cross cultural issues in the context of managed care health services delivery. This overview of recent research on cross cultural health care delivery reveals the spotty need of this area of study and the need for further exploration into this critical area of academic research.

HEALTH BELIEFS

Medical belief systems and attitudes toward provider-patient relationships are significant factors in predicting a minority or recent immigrant's successful health care experience. Repeated studies including those cited below attribute inadequate health care for minority and immigrant populations to an inability to accommodate these beliefs and behaviors in a conventional medical care delivery setting. Researchers such as those whose work is discussed below are coming to question the appropriateness of applying the dominant health belief model to limited and non-English speaking patients. This model is based upon the mainstream population's health behaviors. These are influenced by their perceived susceptibility to and seriousness of disease, and barriers to and benefits from care which they experience. They are questioning the appropriateness of providers' basing their cues to action on these assumptions about their culturally diverse patients. During a time when skyrocketing health costs demand both medically effective and cost-effective treatment, they support the rationale for a cross-cultural approach to health care. The following studies reveal that misuse and underuse of facilities is not merely a question of access, and communication between doctor and patient is much more than language fluency.

In the introductory article to the *Western Journal of Medicine's* first special issue on cross-cultural medicine, medical anthropologist M. Margaret Clark (1983) discusses the nature of cultural barriers in health care, language barriers and communication patterns, appropriate medical roles, influence on patients of explanatory models of disease, differing levels of emotional impact and stigma of various diseases, and a review of available resources on cultural medicine. Nine years later *WJM* published another special issue on the same topic. Judith Barker (1992) compared the two issues, referencing groups covered; population growth and diversification; types of social science represented in studies; ethnicity of authors; and research themes covered. Also in the 1992 *WJM* special issue Linda Haffner gives a "front-line" perspective on cross-cultural medicine, describing how miscommunications, differences in attitudes about health care, and other misunderstandings interfere with successful health care delivery. Using specific examples, Lee Pachter (1994) argues that providers should align

biomedical treatment with the patient's cultural medical model. He describes several common folk illness categories and offers guidelines for evaluating patient beliefs. Addressing the same point for a different ethnic community, Joseph Carrese (1995) examines the Patient Self-Determination Act from the Navaho perspective of *hozho*, a combination of the concepts of beauty, goodness, order, harmony, and the ideal. He emphasizes the conflict with Western medicine's emphasis on exploring and discussing risk factors in disease and treatment. Bruce Vladek (1993) reflects on what happens when the patient's belief system comes into conflict with institutional health beliefs while making the ultimate medical decision: to discontinue or decline life-sustaining efforts.

Hispanics are the fastest growing population in the country. Much recent research on cross-cultural medicine has been targeted to that diverse population. Robert Calatrello (1980) considers some traditional Hispanic health beliefs and perceptions, and argues that difficulties with patient compliance can be traced to culturally determined concepts of illness and treatment. A 1989 COSSMHO publication provides a summary of common Hispanic cultural health beliefs and practices, naming belief models, folk sayings, community healers, and home remedies, and emphasizes the importance of physician familiarity with folk illness beliefs and disease categories to correctly interpret patients' symptom descriptions. Schreiber and Homiak (1981) provide demographic and morbidity tables and a discussion of Mexican American folk concepts of disease and illness, and identify and discuss dynamics of Mexican American patient encounters with mainstream medicine. Harwood (1971) describes Puerto-Rican Americans' Hippocratic "hot-cold" classification of diseases, medications and foods, and offers suggestions for communicating with Puerto-Rican American patients. Sandoval and de la Roza (1986) trace the history of Hispanics in the U.S. and discuss Hispanic social characteristics in addressing the need for cross-cultural training. In that context strategies are offered, with specific examples, for dealing with Hispanic patients in clinical care settings. Graciela Castex (1994) offers a brief profile of Hispanic/Latino population emphasizing such key social characteristics as differences in race, language, national origin, religion, self-identified cultural heritage, and citizenship status.

The burgeoning Asian population groups in the U.S. also present a cultural challenge to the medical profession. Gould-Martin and Ngin (1981) survey migration history, medical research on Chinese-Americans, concepts of disease and illness, and alternative treatments outside mainstream medicine, also discussing how Chinese-American social and medical norms affect patients' experience with medical professionals. An Asian/Pacific Islander Task Force (1984) offers a brief survey of the Chinese-American population's demographics, medical beliefs and family structure, and discusses how social customs and beliefs affect treatment of hypertension in Chinese-Americans. Two articles focus on Filipinos. Cachola (1984) traces Filipino cultural and migration histories, then describes folk medicine and social beliefs and dietary habits that affect onset and treatment of hypertension. Her article concludes with a glossary of common Filipino food items and their sodium contents. James Anderson (1983) summarizes growth trends and demographic and migratory history of the Filipino immigrant population, and discusses genetic predispositions, selected health problems, and health and social beliefs that influence medical care. Guillot, Kaizawa, and Okamoto (1984) discuss how social and cultural customs of Japanese-Americans influence their experiences with medical care. Following is a glossary of native therapies, food-based remedies, and social norms commonly expressed in health care encounters. Laura Uba (1992) reports that, despite severe health

problems among Southeast Asian refugees, as a group they underuse the American health care system. The author argues that cultural beliefs about illness, suspicion of Western medicine, and unfamiliarity with methods of access to health care all contribute to underuse.

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PROVIDER-PATIENT INTERACTIONS

Medical professionals are faced with examining their own cultural and health belief assumptions as they attempt to acknowledge and incorporate patients' beliefs and customs into medical encounters of all types. In a three-part series for *Family Medicine*, Lotte and Alan Marcus (1988, 1989) challenge medical residents to examine their own belief systems as they exercise authority and collaborate with patients of differing medical beliefs and languages/cultures. In Part 2 they present specific examples of miscommunications derived from cultural expectations of medical care, with a discussion of parallel experiences of the elderly. Part 3 focuses both on appropriate and on the currently inadequate role of behavioral science in medicine. The authors argue that practitioners must acknowledge the link between illness and social marginality to provide good family health care rather than context-free "interventions." Raymond Riglioso presents a summary of three kinds of medical belief systems and physician guidelines for incorporating patients' cultural belief perspectives into the health care encounter, as does Lee Pachter (1994). Buchwald and colleagues (1994) discuss how culture influences illness behavior by providing theories of causality and defining ranges of normal and abnormal symptoms. They include demographic tables and suggestions for physicians eliciting information and prescribing treatment courses, and conclude with vignettes and explanation of the cross-cultural communication model, 'LEARN'. Gostin (1995) contrasts the American philosophy of "rugged individualism" that led to the practice of informed consent with cultural contexts that value group/family decision-making. He suggests use of "ethical review" panels to mediate conflict and reduce legal liability. Dennis Mull (1993) describes strategies, attitudes, and investigative methods that increase satisfaction of both physician and patient in cross-cultural medical encounters, and lists recurrent themes in cross-cultural medicine.

A number of sources give a "snapshot", revealing why cross-cultural research into provider-patient interactions is needed, what is currently being surveyed, and recommendations from individual practitioners. The Moy study (1996) shows minority patients are four times as likely as non-Hispanic whites to receive care from non-white physicians. Anne Baye's (1994) interviews highlight the lack of Hispanic nurse managers, and the inaccessibility of the medical

system to Hispanics for research and higher education. She has observed that in addition to language barriers, Hispanic women experience social constraints that prevent them from obtaining the ob/gyn care they need (Savage, 1994). Margaret Gerteis (1995) relates the experience of a research team as it conducted site visits to urban general hospitals across the country. The team found that hospitals usually fall into one of five progressive categories measuring cross-cultural competence. (Full report information is available from Dr. Dennis Andrulis at (202) 408-0229.) Lotte Marcus (1989) calls for deeper history-taking from patients and a more reciprocal relationship between physician and patient, and proposes role of "illness counselor" to facilitate communication.

Significant research targeting physician-patient relationships for specific ethnic groups is a valuable piece of the knowledge base of cross-cultural medicine. The previously-cited 1989 COSSMHO publication identifies some cultural and language factors that affect Hispanics' use of health services and offers specific strategies to overcome language barriers, and to interact effectively and encourage compliance with treatment recommendations. A nurse practitioner working with Hispanic clients (Caudle, 1993) recommends health care providers: view culture as an enabling force rather than resistant; incorporate cultural beliefs in health plans; stress familism; take time for conversation with and about the patient; refrain from harsh criticism; and involve communities in preventive health care programs. In a small Texas study, Cousins and colleagues (1992) found that a culturally and linguistically appropriate program can achieve significant weight reduction among Mexican American women. Fox and Stein (1992) found in an examination of differential use of screening mammography by racial/ethnic groups, that more than half of Hispanic women over 50 in the study had never had a mammogram--more than white or black women the same age. They offer suggestions to physicians about culturally sensitive ways to get more women, especially Hispanic, to obtain mammograms.

Physicians practicing among Asian populations also recognize the need to train medical professionals in cultural competence. The Medical Director of one of the managed care entities profiled in this study, Edward Chow (1981), identifies cultural and language barriers in physician interactions with Asian patients. Han (1984) and Bray (1984) describe the folk and religious beliefs of Koreans and Vietnamese, respectively, and make recommendations for physicians treating those groups.

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LANGUAGE BARRIERS

Fluency in language is a crucial part of a "communication continuum" between medical professionals and their ethnic/immigrant patients. For limited English speaking recipients of federal financial assistance, Title VI of the Civil Rights Act of 1964 stipulates that bilingual services be provided to ensure equal access and participation in these programs. Steven Woloshin and colleagues (1995) observe that even though the Civil Rights Act of 1964 and subsequent federal policy recognize that inadequate interpretation services are a form of discrimination, lack of these services continue to be a barrier to health care for non- or limited-English speakers. Consequences include: not seeking medical care; misunderstanding treatment instructions; and invalid "informed consent." In a survey of multicultural obstetrics patients in five Northern California Kaiser facilities, Husting and Deaton (1993) showed that among patients with lengthy hospitalizations, many needed translation services and/or identified their primary language as other than English. The authors note that the words of a language do not automatically translate the culturally-laden meanings behind the words, or draw out concerns that are left unspoken. Linda Haffner (1992) adds a "front-line" perspective on cross-cultural medicine, and describes how miscommunications, differences in attitudes about health care, and other misunderstandings interfere with successful health care delivery. A key concern regarding interpreter services is the tendency for some providers to use family members - and especially children - to interpret for their parents. Haffner and others argue that this is not appropriate in light of the potential emotional distress it may cause to the children and other relatives involved. Another key concern in providing translation services is the level of literacy of patients in their native languages, and the tendency of health care providers and public agencies to interpret or translate materials for a higher education level than is appropriate. Phillips and colleagues (1994) used Berry's (1969) criteria for cross-cultural research to test cultural equivalence for English-Spanish communications in health care settings. What with the State of California's MediCal Managed Care requirement for all participating health plan materials to be translated into the primary language of targeted non- or limited-English speaking enrollees, the cultural appropriateness and literacy level of the translations becomes a critical issue.

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ETHNICITY AND DISEASE

The pressing need in this area of research is to discuss cross-cultural health care practices in the context of those medical conditions most prevalent among minorities. Research is beginning to yield information from genetic predispositions to certain diseases to cultural factors inhibiting detection and prevention of disease among certain ethnic and racial populations. Unfortunately, none of these insights have been incorporated in the national efforts to establish universally accepted quality assurance measures for health maintenance organizations and other forms of managed care. A 1989 COSSMHO publication, in summarizing information about Hispanics' health and health-related conditions and behaviors, acknowledges that data for such findings is limited. A critical need exists for those establishing nationwide measures of quality of care to address the specific illnesses most affecting minority patients and the effective approaches to treating them. This is especially true of chronic disease conditions, where issues of compliance are often most influenced by the culturally bound beliefs and behaviors of the patient.

Investigating the theory that treatment compliance problems are frequently due to differences between patients' and physicians' explanatory models of illness, Huertin-Roberts and Reisin (1992) found that culturally influenced health beliefs are an important influence on compliance. Discussing HIV/AIDS issues, Soriano (1992) relates this issue to the fact that the proportion of all AIDS cases who are Hispanic are nearly twice the representation of Hispanics in the U.S. population. They discuss the impact of these diverse health belief in the spread of AIDS with recommendations for intervention efforts. Porter and Bonilla also discuss adequacy of the Health Belief Model (HBM) in predicting Latino HIV-testing behavior. Results from a survey adapted for HIV/AIDS showed that the model does not address the cultural factors which are necessary to predict Latino HIV-testing behavior.

Detection and treatment of cancers seem significantly culture-bound. Optenberg and colleagues (1995) evaluated long-term survival of black and white prostate cancer patients. Their analysis suggests that in an equal-access medical care system there are no stage-specific differences in treatment between black and white patients. Survival among blacks is similar to that among whites and may surpass white survival rates for disease. In a survey of adult health plan members, Perez-Stable and colleagues (1995) conclude that misconceptions about cancer are more prevalent among Latinos than they are among Anglos, and that the cultural concept of fatalism may be a determining factor. In a series of articles on Latino health for the *Los Angeles Times*, Di Rado (1992) reported that, even though the types of cancer killing Latinos are those most easily prevented or found at an early stage, they are not detected because of culturally-motivated resistance to testing and language/communication barriers. Stolberg (1992) interviewed experts at the National Cancer Institute who suspect that cultural attitudes and fears

may explain why Latinos, although (with the exception of cervical cancer) they are less likely to get cancers, are equally likely to die of the disease. A study of immigrant Hispanic cancer patients by Arruda and colleagues (1992) found six sources of comfort: nurturing; familiar environment; safety; quality of life; normalcy; and "animo" (courage). As perceived by these Hispanic patients, providers of comfort were self, family, health care professionals, and God.

External environmental factors and internal beliefs also impact a limited English speaking individual's willingness to seek care. Through a series of focus groups conducted by Lantz and colleagues, male and female Hispanic migrant agricultural workers shared beliefs that pesticides are toxic and can cause cancer, but they were reluctant to demand protection for fear of losing their jobs. A lack of knowledge about causes and prevention of cancer were associated with cultural barriers to testing and treatment. Detection and treatment of breast cancer shows strong links with cultural variables. Further study is needed to mine the valuable medical information to be gained. Mickley and Soeken (1993) took a sample of 25 Hispanic and 25 Anglo women with breast cancer who completed a survey investigating respondents' hope, well-being, and religiousness. The significant variable that emerged was Hispanic women's higher score in "intrinsic religiousness." Bertha Mo (1992) explores why breast cancers and other breast diseases often go undetected and untreated in Chinese-American women even though their breast cancer occurrence rates are higher. She cites institutional barriers such as lack of information in the Chinese language, few female physicians, and an absence of educational campaigns as factors in Chinese women's neglect of breast health.

General indicators of treatment and compliance for cardiopulmonary diseases also seem linked to cultural factors. Among Hispanics, culture-related factors appear significant in preventing and treating cardiopulmonary conditions. A publication of the Latino Task Force for the State of California lists health status and risk reduction objectives; policy recommendations; community intervention plans; and resource development suggestions from tax incentives for disease prevention instruction to bilingual/bicultural community health workers. Perez-Stable (1987) also presents a demographic profile of Latinos in the U.S which highlights pertinent health care access issues for Latinos around cardiovascular risk factors, tuberculosis and depression. Peterson and colleagues (1994) also raise similar questions in attempting to understand why blacks received substantially fewer cardiac procedures after AMI (i.e., acute myocardial infarction, or heart attacks) than do whites. Yet, despite undergoing fewer intervention procedures, blacks had better short-term and intermediate survival rates than did whites.

Steven Shea and colleagues (1992) found that characteristics of the health care system, such as absence of insurance or a primary care physician, as well as patients' behaviors and medical belief systems are associated with severe, uncontrolled hypertension. Focusing on the Asian communities, Edward Chow (1987) identifies some problems faced by practitioners treating A/PI (i.e., Asian and Pacific Islander) hypertensives, and discusses how traditional Chinese medicine views hypertension. Han (1984) summarizes ethnic and religious characteristics of Korean Americans. Han then applies these characteristics to the context of treating hypertension, and offers specific culturally-competent approaches for physicians treating Korean American hypertensives. After describing Vietnamese social structure, folk medicine beliefs and dietary habits, Bray (1984) suggests ways physicians may use that knowledge to ensure successful treatment of Vietnamese American hypertensives. Lotte and Alan Marcus

(1990/1991) explore the psychological effect of MS on its victims. They note that, while cultural factors do influence how MS is viewed by patients and treated by physicians, diseases like MS also seem to be a cultural "leveler."

Research shows that the incidence of diabetes is strongly linked to genetic predisposition. It is also influenced by cultural factors such as dietary patterns. The Asian and Pacific Islander (A/PI) Task Force (1991) reported that the proportional mortality of A/PIs is 1.5 times greater than in the white population. The mortality is particularly elevated among Samoan, Guamanian, Hawaiian, and Japanese populations. It is believed that Japanese and other A/PIs may have a genetic predisposition to diabetes that does not surface when eating their native diet. This phenomenon has also been noted in Native Americans. Raymond and D'Eramo-Melkus (1993) speculate that the higher prevalence of non-insulin-dependent diabetes mellitus (NIDDM) among black and Hispanic Americans is due in part to obesity, which is associated with insulin resistance. They recommend that physicians acknowledge and incorporate into treatment specific ethnic beliefs and customs, food consumption patterns, and health care practices. Jose Arevalo has produced a fact sheet for the University of California at Davis showing that Hispanics are more prone to diabetes than whites. This increased risk is due to genetics, diet, poverty factors (little or no medical insurance, low income, lack of education), and language. Arevalo makes recommendations for physicians treating Hispanic diabetics.

Diagnosis and treatment of psychological disorders seem to be culturally linked in ways similar to physiological diseases. In Franks' and Faux's 1990 study of Chinese, Vietnamese, Portuguese, and Latino women, high rates of depression were found for all groups. However, group-specific analyses revealed different models for predicting depression in each ethnic group. The authors indicate need for flexible, individualized approach to ethnic women's psychological care.

Investigation into the area of death and dying has produced insights into appropriate care for terminal patients, with particular implications for managed care, since many of the costlier medical interventions take place in that context. In a 1995 study by Blackhall and colleagues of elderly patients from different ethnic groups making end-of-life decisions, Korean American and Mexican American subjects were more likely to favor a family-centered model of decision-making than the patient autonomy model favored by most African American and European American subjects. Klessig (1992) reports that African-American, Chinese, Jewish, Iranian, Filipino, Mexican-American, and Korean patients were surveyed about their view on life support. Crucial differences among the groups were found in familiarity with high-tech interventions, societal traditions, and personal beliefs and experiences. Through analysis of the death of a Chinese woman with metastatic lung cancer, Muller (1992) discusses issues of a patient's "right to know," interactions of physicians and families of differing cultural backgrounds, and appropriate interventions for terminal patients. Bliatout (1993) describes Hmong religious belief characteristics of ancestor worship, animism and reincarnation, and the components of a traditional Hmong funeral ceremony. He observes that giving up so many religious and funeral rituals in the process of acculturation has caused a high level of stress among Hmong immigrants. Rosenblatt (1993) discusses expressions of grief that are different from accepted majority-culture practices and beliefs, such as "muted" grief, "excessive" grief, associating grief with bodily pain, and "violent" grief. In a study of African-Americans, Hispanics, and non-Hispanic whites, Caralis and colleagues found that African-Americans were

least likely to request euthanasia. Patients from all groups were twice as willing to allow their families to decide about mercy killing than they were to allow their physicians to decide. Racial and ethnic differences persisted across socioeconomic lines. White (1987) describes one Navajo man's experience of losing his wife to tuberculosis, and explains some Navajo traditions and attitudes toward death.

Some significant studies also have resulted from concerns for the variation in response to medicines by individuals from different ethnic and racial backgrounds. The National Pharmaceutical Council has published a valuable document which reviews the genetic factors that underlie varying responses to medication. It focuses on the pharmacogenetics of drug metabolism, the environmental factors, and how cultural and psychosocial factors may affect the efficacy of or compliance with drug therapy. Levy (1993) also has investigated the effects of environmental factors such as diet, age, and exposure to chemicals; cultural factors such as medical beliefs and compliance with medical treatment; and how genetic factors affect reactions/responses to prescribed drug treatments.

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ACCULTURATION VS. SOCIOECONOMIC STATUS

Cultural/ethnicity and socioeconomic status represent two distinct approaches to predicting social behaviors among limited and non-English speaking minorities. Awareness of a patient's strongly held cultural health belief models and related social habits as well as his/her socio-economic status can help providers anticipate the needs of immigrant and minority patients. Development of a measurable "acculturation" test with a mix of cultural and SES indicators is a major focus of recent studies to improve medical care delivery and assess quality of care issues.

A study by Adler et al. (1993) stresses that socioeconomic status (i.e., SES) is a strong and consistent predictor of morbidity and premature mortality. She and her colleagues note how SES contributes to the development during childhood of traits and coping resources that may affect risk for disease. Haas and colleagues (1994) found that hospitalized asthmatics of lower socioeconomic status have worse health outcomes post-discharge, which appear due in part to less continuous and less intensive treatment. In a study of preschool children with asthma, Finkelstein and colleagues (1995) also found that young asthmatics from racial minorities admitted for treatment were less likely to have received maximally effective preventive therapy. Finkelstein also noted marked differences in post-hospital care for black and Hispanic patients when they were compared with white patients. Another study by Husting and Deaton (1993) of obstetrics patients at five Kaiser facilities in Northern California found that women requiring more than two days hospitalization after delivery tended to have a language other than English as their primary language.

Hennessy and Friesen (1994) found that subjects in the lower socioeconomic groups were less satisfied with medical care. The primary dissatisfaction was not with technical or skill levels of care provided, but with the environment and lack of "caring" with which medical services were delivered. Montalvo (1992) explores the issue of racial self-perception and education and income levels according to skin color. He cites many studies dealing with the facets of phenotype effects, including mental health. Arnold and Orozco (1989) found that both adaptive behavior and response to language-based rehabilitation programs were higher in more acculturated Mexican-Americans with disabilities than they were in less acculturated Mexican-

Americans with similar disabilities. Data on smoking behavior among Hispanics obtained from the 1982 and 1984 Hispanic Health and Nutrition Examination Survey (HHANES) were compared by Perez-Stable and colleagues (1990) to results from a telephone survey in 1986-1987. Findings included higher smoking rates for more acculturated Mexican American and Central American women, but lower for more acculturated men than was the case among their less acculturated brethren. This parallels inter-SES differences in smoking behavior within white non-Latino populations, which implies the importance of socio-economic level for smoking cessation. A study by Daniels and Rene (1994) of Blacks with hypertension also observed that race is not a marker for other characteristics (income, education, age, etc) capable of explaining differences among blacks compared with whites.

A study by Stein and colleagues (1992) assessed the relative influence of the health belief model on mammography use and intention to use. Findings showed that socioeconomic status did not appear to influence previous mammography experience directly, but that culturally-related factors are significant. Nagy and Woods (1992) conducted a review of studies addressing acculturation with the variables family socialization, social-support networks, alcoholism, and psychosocial adjustment. These authors gave emphasis to two methodological weaknesses in all the studies: lack of a satisfactory scale to measure acculturation, and excessive reliance on "self-reports". Marin and colleagues (1987) developed and tested a 12-item acculturation scale for Hispanics. Three factors - language use, media preferences, and ethnic social relations - correlated highly with respondents' generation, length of residence in the U.S., age at arrival, and ethnic self-identification.

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ETHNIC IDENTIFICATION

Development of consistent categories for identification is desirable for accurate predictive research data, but frequently difficult to accurately assign given the many available variables (national origin, religion, mixed genealogy, socioeconomic status, self-perception, etc.). In a study of the consistency of racial and ethnic classification of U.S. infants for infant mortality data, Hahn and colleagues (1992) found that the coding of race and ethnicity at birth and death is remarkably inconsistent, with a significant impact on the estimation of infant mortality rates. Huth (1995) notes that "race" as a precise taxonomic category is not a meaningful descriptor for human population groups with their wide intra-group variations in genetics and customs. He challenges researchers to provide clear justifications for using ethnicity as a variable in studies, and not merely as a factor for "fishing expeditions" to account for unknown variances. Caldwell and Popenoe (1995) observe that, although labels such as "black" and "white" are sometimes helpful to the clinician, they can also interfere with accurate diagnoses and therapeutic help, and are an inconsistent indicator of genetic risks and perceptions of disease. Dumbauld and colleagues' (1992) review of available literature revealed numerous problems with classification of individuals into racial/ethnic groups. They found birth statistics to be more reliable than death statistics, presumably because death information is always second- or third-hand. They proposed breakdown of data into ethnic subgroups as a solution, especially with reference to Asian/Pacific Islander populations. Osborne and Feit (1992) discuss practical problems with racial classification, such as the influence of researchers' racism and other sources of bias. They caution against using race as a "surrogate" factor in studies of social misbehavior, when determining factors are more likely due to conditions resulting from low socioeconomic status.

In response to Osborne and Feit, Manning Feinleib (1992) argues that, when properly used, race can be a valuable indicator in medical research. For example, finding in 1980 that black men were 20% more likely to smoke than white men allowed health authorities to target

a health education program at the black male population. The value of ethnic data collection is also noted by Gill and Johnson (1995). They note that ethnic data collection is needed to discover reasons for underuse of the medical system by minorities, and to find causes for such specific situations as why there are excessive referrals of Asian patients for gastroenterological investigation with no apparent clinical justification. They advocate using the category "ethnic group" rather than "race," to permit more accurate self-identification. To establish ethnicity as a valid predictor for health behaviors, Yu and Liu (1992) recommend that the National Center for Health Statistics (NCHS) apply resources to improve ethnicity data collection of A/PI populations, first in California, New York, and Hawaii, then extended to the 10 states where 79% of the population resides, or to the top 15 metropolitan areas where they are concentrated. Robert Hahn (1992) identifies recommendations for the improvement of federal health statistics for racial and ethnic groups: (1) clarification of goals for classification; (2) adoption of scientific principles to validate and define the categories "race" and "ethnicity"; (3) assessment of perceived social identity; and (4) periodic evaluation.

Researchers have sought to define "race" and "ethnicity" in their studies, and to identify research approaches to elicit ethnic and cultural sensitive data. One method of obtaining accurate and broad-based information on ethnic/minority populations is the focus group. Naish and colleagues (1994) used focus groups to discover that women from ethnic minorities are enthusiastic about cervical screening once they understand the purpose of the test, and recommend that focus group surveys be carried out on other aspects of health promotion. Nyamathi and Shuler (1990) conducted a study with black and Hispanic women at risk from HIV, and found that focus groups are a highly effective method of disseminating information and tailoring a preventive education program.

Another effective method of obtaining information relevant to culturally competent health care is the patient survey. Carey and Seibert (1993) conducted a four-year study and testing of patient survey instruments for inpatients and outpatients. Both questionnaires showed strong evidence of internal consistency, construct validity, and predictive validity. Carl Nelson (1990) analyzed the survey instruments of five teaching hospitals, three community hospitals, and two health maintenance organizations. He found that insufficient attention is often paid to patient satisfaction with technical competence and patient expectations.

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ETHNICITY AND MANAGED CARE

Across the nation, an increasing number of states or counties are mandating managed health care for Medicaid beneficiaries and poor people. This trend raises issues of access and satisfaction with care. These issues are often influenced by cultural criteria. As health policymakers continue to study and weigh tradeoffs between managed care and independent fee-for-service provisions, factors of ethnicity and culture should be taken into consideration.

The impact of cultural and ethnicity on the level of member satisfaction with managed care plans has been the subject of several studies. Siddharthan (1990) found that native U.S.-born health plan members cite health status, physical access to facilities, and income levels as determining factors in enrolling in managed care plans. However, among foreign born nationals, race appears to play an important role in choosing health care plans. Specifically, immigrant populations look to the availability of ethnic-sensitive providers in choosing a health plan. Temkin-Greener and Winchell (1991) conducted a survey of satisfaction among Medicaid patients in Monroe County, New York, site of a mandatory, prepaid, managed care program. While non-white participants rated the program lower than did whites for quality of care and convenient access, their overall rates of satisfaction were higher than with the former Medicaid program. In a study that explores culturally-competent health care delivery in managed care

settings. Tirado (1994) discusses factors contributing to Chinese and Latino member satisfaction in minority owned and operated managed care plans.

A number of studies express concerns about the capacity of managed care systems to provide equal access to health care for low income minority populations (Ware et al. 1986). One study by Wood and colleagues (1994) finds that in the absence of meaningful financial incentives to encourage private physicians and HMOs to provide immunizations to inner-city children, managed care is unlikely to improve immunization rates. This finding is noteworthy because California plans to enroll half of its Medicaid population, 75% of whom are children, into managed care. Diana Sugg (1995) reports that Baltimore children in Medicaid programs experience delays of up to three months for routine screening exams and immunizations. Even though Maryland has recently added a financial penalty for HMOs that do not treat in a timely manner, the state still plans to enroll its 467,000 Medicaid recipients into HMOs.

Oversight and accountability of managed care organizations are issues of concern for advocates for immigrant and minority patient interests. This issue has become more significant as states look to managed care as the cost-effective approach to addressing the needs of Medicaid beneficiaries. A recent report by the Latino Issues Forum entitled "Left Behind" notes that marketers for some managed care plans have been accused of spreading false information about termination of Medicaid benefits and exaggeration of HMO benefits in order to boost enrollment in the managed care plans they represent. The General Accounting Office of the U.S. Department of Health Education and Human Services found a generally low level of contract manager and technical expertise among DHS managers in monitoring the level of access and quality of care provided to low income populations.

Mokaua and Fong (1994) argue that improvement in services for minority people of color needs to focus on the criteria of: (1) availability; (2) accessibility (affordability, location in high risk communities); and (3) acceptability (staffing with culturally-competent, bilingual/bicultural providers). The authors suggest that these three criteria should be used in estimating the responsiveness of health care services for ethnic minority groups. From the managed care perspective, Judy Packer-Tursman observes that a growing numbers of HMOs, driven by their increasingly diverse client bases, are making a concerted effort to increase the number of minorities on their corporate staffs and physician rosters through increased recruitment and training.

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E. FINAL RESULTS

Work completed on the Latino Coalition project has produced the following results:

- 1) **Summaries of the findings of the first and second Physician Panels and of the two patient panels, and an analysis of their contribution to our understanding of the culturally competent model of health care delivery in the context of two of the largest minority run health maintenance organizations in the State of California.** These summaries are included in this report as Sections II and III below.
- 2) **A Patient Satisfaction Survey** which can be used as an instrument for evaluating the degree to which a managed care plan is providing culturally competent health care to its limited English speaking minority enrollees. Accompanying this survey is an annotated description of the rationale behind each of the questions. As discussed both above and below, panelists were able to develop a single instrument which, when translated into the appropriate languages and presented in the appropriate manner, could be used to survey members both of the Chinese and of the Latino communities regarding their satisfaction with the care provided

them. The survey instrument and annotated description form Section IV and Appendices 2 and 5 of this report.

- 3) **A Provider Self Assessment Survey** for use with physicians and other health care providers working under a system of managed care. This instrument is intended for use as a guide to these providers in determining the degree to which they could benefit from further training or experience in providing culturally competent health care. This section of the report also includes an annotated summary of the thinking behind the Panels' and Project staff's development of each of the questions. The Provider Self Assessment Survey is included as Section V and Appendices 3 and 6 of this report.
- 4) **Behavioral Ethnic Identifiers** which can be used in enrollment forms as a cue for the provision of culturally appropriate health care services by an enrolling health plan. This section of the report reviews current approaches to collecting and applying ethnic identification information by federal and state authorities. It suggests methods by which such processes may better serve the needs of health care providers as they prepare to receive new minority enrollees from limited English speaking culturally diverse backgrounds. The discussion of Ethnic Identifiers is included as Section VI of this report.

II. SUMMARY OF FIRST PHYSICIAN PANELS

A. CHINESE PHYSICIAN PANEL (First Round)

1. PANEL COMPOSITION

The Chinese Community Health Plan panel was composed of 8 doctors engaged in primary care. These doctors are practicing physicians in San Francisco who have predominately Chinese and Chinese American patients. The following is a list of the individuals with their medical subspecialties. All but two of these doctors were educated in the U.S.

Ken Chan, M.D.	Internal Medicine/ Pulmonology
S. W. Chan, M.D.	Internal Medicine/Cardiology
Edward Chow, M.D.	Internal Medicine
Tina Kwan, M.D.	Pediatrics
Randall Low, M.D.	Internal Medicine/Cardiology
Collin Quock, M.D.	Internal Medicine
Ho Tan, M.D.	Family Practice
Winchell Quock, M.D.	Pediatrics

2. AGENDA

This panel was co-led by Edward Chow, M.D., the CCHP Medical Director, and Miguel Tirado, Ph.D., the Project Principal Investigator. The agenda of the meeting focused on

following topics:

- 1) Discussion of culturally competent approaches to diagnosis and treatment;
- 2) Evaluation of the patient satisfaction survey instrument for use with limited and non-English speaking patients;
- 3) Discussion of the Provider Sensitivity Scale; and
- 4) Review of ethnic identifiers used by both the State of California and the Federal Government for medical enrollments.

3. FACTORS COMPLICATING THE CLINICAL CARE OF CHINESE PATIENTS

The panel's discussion of factors which complicate the clinical care of Chinese patients commenced with the general acknowledgement that the diagnosis and treatment of Chinese patients requires special knowledge and skills which go beyond nationally accepted standards of practice. Among the factors panel members felt argued for distinctive approaches to Chinese patients in a primary care setting are the following:

- 1) **Different Perceptions of Symptoms.** Chinese patients seeking care frequently focus on single relatively minor symptoms (e.g., dizziness) rather than discussing more serious conditions (e.g., loss of consciousness). The sets of terms used to communicate about symptoms may differ from one subset of clinical patients to another. These terms are often imprecise. This can lead the novice clinician to misperception.
- 2) **Professional respect and personal modesty.** Chinese patients tend not to challenge doctors' questions or recommendations due to personal modesty and/or as sign of respect. This deference makes accurate medical history taking more difficult. Due to deference, a patient may fail to correct a physician's misunderstanding of the patient's comment.
- 3) **Ethnically linked prevalence patterns.** Chinese patients have an increased susceptibility to certain diseases which are not commonly found in the dominant Caucasian U.S. population. Examples of such conditions are G-6PD deficiency, liver flukes, hepatitis B, and nasopharyngeal cancer.
- 4) **Ethnically linked idiosyncracies in medication responses.** The pharmacokinetics of various drugs are altered by the different liver metabolism typical among the Chinese. Ethnic idiosyncracies in medication responses include a greater potential for over-dosage of pain medications. Another example is Chinese patients' greater sensitivity to the side effects of certain blood pressure medications.
- 5) **The expectation that treatment is a part of every doctor visit.** A physician visit which only involves diagnostic tests, with no shots or other treatment being provided, implies 'physician incompetence' to many Chinese patients.

- 6) **The perception that medication side effects are a sign of poor quality medical care.** When side effects occur, this perception further aggravates Chinese patients' readiness to switch physicians or seek alternative Chinese remedies.
- 7) **Dropping treatment when symptoms subside.** This tendency is particularly strong for less educated Chinese patients. This can lead to serious adherence problems and the increased risk of otherwise avoidable disease progression. Less assimilated Chinese patients also tend to assume that treatment is the same thing as cure. This expectation also encourages Chinese patients to become easily dissatisfied with physicians when conditions do not resolve immediately, and leads them to switch doctors.
- 8) **Reliance on Chinese medicines.** This reliance on traditional Chinese medicines is especially likely for those chronic health conditions where traditional treatment is perceived by many Chinese as more beneficial and freer of side effects. Simultaneous combined use of western and traditional Chinese medicines creates the potential for adverse interactions with Western medications and/or for abandonment of Western treatments. The pediatricians in the panel reported several examples of children who were rushed to Emergency due to complications from the inappropriate mixing of treatments drawn from the two traditions.
- 9) **Key decision makers on health decisions being often neither the patient nor members of the patient's nuclear family.** In the case of children, the patient's parents may not control the child's care. Instead, the grandmother frequently plays this role for grandchildren. If the physician fails to include the latter in discussions about the patient's treatment, it is possible that the doctor's orders will be undermined either by the grandparent or by a relative who provides daycare for the child.
- 10) **Family members' frequent temptation to hide medical information relating to the patient's condition from the patient.** This is especially likely when the eldest son or daughter is responsible for the care of his/her parent and that parent is receiving care. The result is that the patient may not be conscious of the true nature of either their condition or treatment.
- 11) **Use of imperfect family interpreters.** Use of such family-specific translators can bias transmittal of clinical information to and from the patient (cf. III.A.3.10) above). This potential bias is aggravated by the fact that some medical terms in Chinese may not have precise relationships with concepts in Western medicine (e.g., the liver).
- 12) **Linguistic (particularly dialectic) diversity.** Recent Chinese immigrants may speak any of many different Chinese dialects. This linguistic diversity may be present among enrollees with any health plan. At the minimum, health plans should ask if a patient speaks Mandarin or Cantonese. A fuller investigation of linguistic comprehension would include Cheu-chaio, Sai-yup and Shanghainese. The latter are dialects commonly spoken among segments of the Chinese

immigrant population. The Panel argued that accommodation by the health plan to these different dialects was critical to ensure that immigrants are provided with appropriate medical care.

4. PHYSICIAN/PATIENT COMMUNICATION

These above insights led the panelists to discuss the approaches they use to overcome such language and cultural barriers to physician patient communication. They recommended the following approaches:

- 1) **Prescribe medications in smaller dosages or number of units.** Writing prescriptions in smaller dosages or numbers of units requires the patient to visit their physician more frequently for refills. This requirement for frequent visits helps Chinese patients to avoid the inclination to cease compliance with their drug regimens either when side effects occur or when the symptoms cease.
- 2) **Minimize the number of medications given at any one time.** Limiting the number of medications prescribed simultaneously reduces confusion among the limited English speaking Chinese patients, and lessens the chance of their failing to adhere to prescribed drug regimens.
- 3) **Acknowledge the patient's use of traditional Chinese medicines along with Western medications.** Where the potential for adverse interactions among particular medications drawn from these two different pharmacopeia exists, the doctor should stress the consequences of their misuse. According to Dr. Hui, the subject of mixing and matching of Chinese and Western treatments is little understood in this country. Even the Chinese physicians on the panel were not fully conversant with the range of interactions involving Chinese and Western medications. Nevertheless, they were quick to give examples of adverse consequences resulting from mixing agents drawn from the two medical traditions.
- 4) **Include all relevant family decision makers in office visits.** Relevant family members should be included in office visits where treatment processes are discussed. This inclusion seeks to lessen the chances that a non-present family member will undermine or shield the patient from treatment recommendations or from the facts of their condition.
- 5) **Acknowledge the Chinese patient's expectations regarding the relationship between the office visit and treatment or cure.** This acknowledgement is an important starting point because Chinese patients often assume that a physician visit and provision of a treatment are synonymous. Patients may conclude the care provided at a physician visit was inadequate if no medications are prescribed or injections given at that visit.

- 6) **Increase the number of office visits per year for Chinese patients with chronic conditions.** The standard health maintenance organization norm of 3 visits per year is not appropriate for many of the less educated limited or non-English speaking patients because such patients may require more physician monitoring of their adherence to recommended medication regimens and other treatments to achieve acceptable levels of adherence. The panel noted, however, that this approach was likely to flag culturally competent physicians as outliers in their managed care health plans.
- 7) **Use multiple questions to ascertain the nature of the patient's symptoms.** Doctors should avoid over-reliance on the interpreter's accuracy and/or the family member's description of the patient's condition. Due to the large number of dialects spoken by Chinese who are recent immigrants, physicians should also not assume that all of their patients would be able to understand an interpreter who speaks only Cantonese.
- 8) **Written Patient Satisfaction Surveys of members of the Chinese community have only limited validity.** The panel noted that paper and pencil survey instruments incorporating items requiring yes or no answers tend not to result in objective responses from their patients. Instead, panel members suggested more open ended essay type questions be incorporated in any questionnaire. They also noted that surveys directed to family members who were not the family's real decision makers, and illiteracy problems of several of their patients made it difficult for the target respondent to fill out a questionnaire. The latter problem was particularly important for questionnaires written in English. However, when panelists were presented with an illustrated questionnaire using visual images, they felt that such an instrument might be perceived as demeaning and/or culturally irrelevant to their patients. Rather than using written instruments in satisfaction surveys, they urged the use of personal interviews where possible to follow up on the open ended questions. Thus, they have found that telephone interviews tend to receive more cooperation among Chinese than do written surveys. They noted that any survey requires extensive preparatory outreach to the community. This outreach should involve both contacts with community leaders and adequate advance notification to the respondents on the nature of the survey. Both work to allay the fears that many Chinese immigrants have of formal inquiries from governmental or other outside agencies. Panelists also stressed the value of personal face to face interviews. Many Chinese patients in San Francisco lack telephones. This lack makes it very difficult to conduct phone interviews with them.
- 9) **Health Status Inventories developed for Caucasian respondents are too culturally specific to permit their general use with Chinese patients.** There are major intercultural differences in the importance attached to particular symptoms and the interpretation of various emotional reactions to them. For example, among Chinese patients the perception of pain tends to be seen as more of a normal dimension of life. Hence the pictures of sad faces relating to questions of pain tend not to receive a response which would be accurate among

Caucasians. Panelists also thought that pictorial questionnaires (e.g., the Dartmouth Coop Health Status Inventory) would be perceived as demeaning by their Chinese enrollees.

- 10) **Provider cultural competence includes facilities.** Health care facilities such as the health plan's hospital, long term and home care facilities play important roles in care processes. The assessment of a mainstream HMO's capabilities should include an examination of the cultural competence of their various facilities.

B. LATINO PHYSICIAN PANEL (First Round)

1. PANEL STRUCTURE

The Latino panel included primary care physicians, a clinical psychologist and other health care professionals from the Community Health Group of San Diego County (CHG). The panel was led by Dr. Antonio Linares, the Plan Medical Director and Dr. Miguel Tirado, Ph.D., the Project Principal Investigator. Participants in the panel included the following individuals with their sub-specialties:

Martha Capizzi, M.D.	Family Practice
Martha Jazo-Baget	CHG medical case management
Enrique Espinosa, M.D.	Internal Medicine/Nephrology
Patricia Lozada	CHG health promotion coordinator
Antonio Linares, M.D.	Family Practice
Manuel Ramirez, M.D.	General Medicine
Gonzalo Ruiz, M.D., M.P.H.	Preventive Medicine
Gregory Talavera, M.D., M.P.H.	Preventive Medicine
Roberto Velazquez, Ph.D.	Clinical Psychologist
Linda Cory Allen, J.D.	Patient Advocate

2. AGENDA

The panel was asked to address the same questions posed to the Chinese Physician panel. It was asked to focus on those culturally competent health care practices which are used in addressing the needs of a predominately Latino Medi-Cal population. The following guides were used to focus their discussion:

- 1) **Evaluation of the patient satisfaction survey instrument for use with limited and non-English speaking patients;**
- 2) **Discussion of the Provider Cultural Competence Scale;**
- 3) **Review of ethnic identifiers used by both the State of California and the Federal Government for medical enrollments; and**
- 4) **Practice standards for the three target conditions of asthma, diabetes and hypertension.**

3. FACTORS COMPLICATING THE CLINICAL CARE OF LATINO PATIENTS

The Latino Physician Panel, paralleling the conclusions of the Chinese Physician Panel, also stressed the need for special knowledge and skills in the treatment of limited English speaking Latino patients. Several factors were identified which complicate the clinical care of Latino patients who exhibit strong behavioral ethnicity. Among these factors were the following:

- 1) **Reliance on "indirectas".** Latino patients may use a form of communication which discourages frank communication with the health care provider. Instead of expressing negative feelings regarding their care or condition directly, they are likely either to withhold such information or to share it in more subtle ways. For example, a Latino patient may be discouraged by the side effects of the treatment his/her physician has ordered. This discouragement may, in turn, provoke feelings of frustration with the doctor. However, the physician may never be confronted with this information directly, and may only receive indirect cues from the patient. The patient may express these feelings by saying, for example "I had trouble taking my medications this week," leaving it to the doctor to probe for any deeper concerns.
- 2) **Wall of deference.** The role of deference and respect for authority among many Latinos are attitudes which contribute to this difficulty many Latino patients have in communicating directly with a doctor. Physicians are highly esteemed and given great respect in Latino culture due to their healing role and education. The result is that Latino patients may be more reluctant than are their more mainstream Caucasian counterparts to confront doctors with questions or to share information which suggest doubts about what doctors said or prescribed. The absence of direct eye contact with authority figures also should not be perceived by providers as a sign of lack of interest in the doctor's communication.
- 3) **Call for respect.** Making interpersonal respect evident is an important underpinning to interactions among Latinos. Evident respect is also important in Latino patients' expectations regarding treatment by providers. Physicians run the risk of being perceived as disrespectful to the extent that they ignore structured cues to communication (e.g., by failing to refer to married female patients as "señora"). Doctors are likely to receive little cooperation from patients who they treat curtly. The fact that Latino patients tend to defer to and not assert their views with doctors should not be misconstrued as suggesting that they respond passively to being treated disrespectfully. In fact threats to the pride of seemingly passive Latino patients by culturally incompetent physicians can provoke a stronger reaction against the doctor as would be the case with more assertive patients.
- 4) **Personalism and non-verbal cues.** The absence of personal rapport with their physicians can also obstruct effective communication with Latino patients. If patients perceive a provider as cold and impersonal, the latter's ability to foster

adherence with his/her treatment regimens can be severely compromised. Sensitivity to non-verbal messages of interpersonal warmth (e.g., physical touch or proximity) and attentiveness are critical skills for physicians to use in their interactions with Latino patients. Animated behavior in expressing pain by Latino patients (e.g., by moaning) is also a reflection of the importance of accurately reading non-verbal cues.

- 5) **Facade of fatalism.** The tendency to perceive misfortune as an integral part of life is a strong component of Latino culture. This sense of resignation to one's fate frequently manifests itself in the clinical setting as a misperception that certain conditions are untreatable and are certain signs of impending death (e.g., cancers). Unfortunately, such an orientation can lead physicians to assume that patients are unwilling to cooperate with diagnostic testing and/or treatment. It is important for providers to understand that this fatalistic orientation can be overcome through the establishment of personal rapport and the appropriate use of the patients' family members to enlist the patients' active cooperation.

4. PHYSICIAN/PATIENT COMMUNICATION

The panel's discussion of factors which complicate the clinical care of Latino patients began with the agreement that cultural competence in the care of Latino patients requires specific alterations to practice patterns appropriate for Caucasian patients. The panel made several observations based on its personal experiences caring for Latino patients and on its discussions of the background materials which had been provided by project staff. Among the factors panel members felt argued for distinctive approaches to Latino patients in a primary care setting and recommendations for provider strategies are the following:

- 1) **Relevance of culturally competent care for chronic conditions.** Culturally competent health care is most applicable to patients with chronic asymptomatic conditions such as hypertension, and for other clinical conditions where symptoms are often less clearly such as diabetes. In contrast, conditions such as asthma, which elicit clear cut symptoms requiring immediate attention, are less dependent on culturally competent care to ensure adherence.
- 2) **The use of the extended family and neighbors by physicians.** Involvement of significant extended family members in the care process is critical to ensure Latino patients' adherence with health prevention and treatment recommendations. In addition to nuclear family members, neighbors who share the patient's condition or have knowledge of the disease are extremely helpful in promoting appropriate patient behavior. Such neighbors can do much to overcome many Latino patients' tendency to deny their condition. One example of family involvement is enlisting the husband in physicians' efforts to get spouses to plan wholesome cooking at home. It also is helpful to emphasize importance of adhering with treatment recommendations for the sake of their children.

- 3) **Physician acknowledgement of patients' mixing and matching of both Western medicine and traditional remedies.** This acknowledgement should occur early in the development of relationships with patients. The panelists observed that patients are more adherent with Western treatment recommendations once their traditional cultural beliefs and practices are recognized by physicians. The mixing of different Western and traditional medical treatments is especially common along the U.S./Mexican border. In that area, patients often will seek "quick fixes" in Mexico (e.g., antibiotics, etc.) when frustrated with the more methodical nature of U.S. physicians. Another reason for use of other sources of Western medicine is the feeling of being treated as "private patients" across the border. This contrasts with the common feeling of being "just a clinic patient and one of the herd" when many Latino patients receive care from sources of Western medicine available in the United States. To the extent physicians can cope with these individuals' dual belief systems, they can help to guide patients in picking and choosing from among the various treatments.
- 4) **Physicians' spending more time with patients to establish communication and trust.** As a result of the "indirectas" discussed above, the last complaint expressed by patients as they leave the appointment room is frequently the most significant one. This additional time is also needed to allow physicians to stress the side effects of prescribed treatments. This is critical to avoiding patient surprise and maintaining communication with the patient and patient adherence if and when side effects do occur. The additional time is also needed to stress to patients the importance of adhering to treatments for the sake of their children. It is also useful for providers to have eye contact, touch patients, and share their own background to establish trust. Unlike Asian patients, Latinos are more responsive to physicians who seek to relate to them on their level rather than from a professionally superior position. It is useful to schedule more frequent visits with these patients to allow for this needed extra time.
- 5) **Physicians' use of "indirectas" when communicating with Latino patients.** Use of indirectas involves saying things in a non-threatening way that elicits the patients' involvement in the care process. One example is the phrase "I want to help you and you need to help me." It is also important for physicians to avoid scolding when faced with patients' failure to adhere to treatment orders.
- 6) **Physicians' identification of the patient's level of acculturation early in physician/patient interactions.** Questions relating to identification of behavioral manifestations of ethnicity are helpful in this regard. Helpful questions to ask are "Where were you born?", "How many years have you lived in this country?", "What language do you speak at home?", etc. Where feasible (i.e., in non-emergency situations), answers to these questions should be recorded by health plans prior to physician visits.

C. ANALYSIS OF INITIAL RESULTS FROM THE FIRST ROUND OF PANELS

1. GOALS

As specified in the initial agreement, the first eight weeks of the project were to involve:

- 1) literature review and consultation with academic experts on cultural and linguistic diversity;
- 2) preparation of initial drafts of a patient satisfaction survey and provider sensitivity scale; and
- 3) convening of health plan physician panels.

The project team leaders were Drs. Chow, Linares, and Tirado. From these endeavors, the team leaders defined the project's course for the succeeding twelve weeks and the nature and scope of the final deliverables. The original intent of the project remained to develop instruments which can be used by HMOs to monitor their progress toward the achievement of culturally competent health care delivery. These above steps led to the physician panels review of the overall scope of the project. In the case of the patient satisfaction survey, all panel members were presented with a draft questionnaire.

2. RESULTS REGARDING CHINESE PATIENTS FROM THE CHINESE PANEL

The review by the CCHP physicians of the patient satisfaction survey focused on the appropriateness of using a highly structured paper and pencil survey requiring objective yes-no answers. They argued that their Chinese patients would find it difficult to answer such a questionnaire objectively unless they also could express their views with more open ended questions. Such questions could take the form either of follow-up questions to yes/no responses, or of personal interviews by bilingual interviewers. They argued that rigid yes or no questions tended to elicit only yes responses, due to patients' politeness and deference to the doctor (cf. above discussion).

Panelists also cautioned that Chinese patients' perceptions of the quality of care they receive were often not the driving force in making health care decisions. Rather, other members of the non-nuclear families may be the key decision makers regarding patients' care. Panelists also cautioned that patients' willingness to change physicians may be more a reflection of their or a responsible family member's misunderstanding of the nature of Western medicine rather than of physician inaction.

3. RESULTS REGARDING LATINO PATIENTS FROM THE LATINO PANEL

The Latino panel also felt that the draft physician survey must be reworked. Panelists recommended including in the questionnaire new physician personal history questions. These

address the fact that physicians might be unable to take a medical history or conduct a physical examination with non-English speaking patients even though the physicians spoke the patients' language. The CHG Medical Director, Dr. Linares, expressed interest in testing this survey on a broader group of physicians practicing in his plan to compare their responses with their personal history and exposure to non-English people and languages. The Latino panel also suggested not separating the responses in the survey by each separate target condition.

Regarding the patient satisfaction survey, the Latino Panel was more receptive to structured questions than were the Chinese panelists. However, the Latino panelists felt that several of the questions in the draft questionnaire would be easily misinterpreted by their patients and would not elicit genuine responses. They argued for phone interviews wherever possible to follow up on responses to the structured questions. They also recommended that patient survey data be gathered primarily from ongoing patients who had been with a health plan for a while. This is because the greatest impact of culturally competent health care is likely to be with ongoing patients suffering from chronic illnesses. In these cases, it is important to have knowledge of the patients' native tongues, of where they were born and raised, and of the nationalities of their parents.

4. RESULTS REGARDING ALL PATIENTS ON WHICH BOTH PANELS CONCURRED

a. Limited Usefulness of Existing Satisfaction Surveys, Health Status Inventories, and Other Survey Instruments

The general conclusion of both panels was that most patient satisfaction questionnaires are ineffective with limited or non-English speaking patients. These questionnaires fail to elicit the real perceptions these patients have of their care. Existing satisfaction questionnaires also tend to emphasize experiences (e.g., waiting times) for which different cultures have different tolerance levels. In the case of Latino patients, the panel argued that more questions are needed to address the experience of patients in their personal interactions with providers. Both the Chinese and Latino panels questioned the viability of the Health Status Inventory as an objective tool of evaluation. They questioned that viability because the typical patient of a commercial HMO has very different perceptions of wellness and feelings of discomfort and pain than do the members of a diverse minority culture. The stoic response of many Latino patients to physical suffering may lead them to understate the true nature of the rest of their physical well being. That is, they may respond to questions of physical and functional status in a more positive way than actually reflected by their condition. Even questions requiring a quantitative rather than qualitative response are susceptible to such understatement.

For Chinese patients, the problem of accurate health status self-reporting is aggravated by their low threshold for experiencing certain physical conditions (e.g., light headedness) and the slight attention they pay to other conditions (e.g., constipation or vertigo). The Chinese panel noted that these patterns of attention and inattention frequently stem from their patients' tendency to follow traditional Chinese beliefs and relate certain symptoms to other unrelated elements of the body (e.g., the liver). Panelists were presented with a pictorial questionnaire (i.e., the Dartmouth COOP Health Inventory) as a possible method for conducting a health status

survey. However, the panelists viewed this approach as demeaning to the patient's intelligence and likely to be resisted by them.

The conclusion of both panels was that the effort to prepare a paper and pencil culturally competent health status inventory was inappropriate at this time. One of the Medical Directors even argued that case management is preferred over health inventories as a device for monitoring patient condition in the current commercial managed care setting. Consequently, they felt the focus should be upon the physicians' ability to extract patient and family history from the doctors' personal interactions with the patients in the office setting. Rather than a health status inventory, panelists felt that there was a greater need for a vehicle to assess primary care physicians' awareness of and sensitivity to issues of cultural competence in their delivery of care to limited and non-English speaking patients.

b. Impact of Wider Efforts to Standardize Quality Assessment

All of the panelists were conscious of both State of California and national efforts to establish standardized techniques for assessing the quality of managed care (e.g., HEDIS). They acknowledged that their willingness to work toward developing a culturally appropriate questionnaire was increased by their desire to counter the imposition of a single standard survey instrument. They also urged the project team to review the CHG patient satisfaction survey for insights regarding data compiled on patients whose primary language is Spanish.

c. The Content of Culturally Competent Health Care

Both physician panels reviewed the draft of a physician questionnaire which asks respondents "What constitutes culturally competent health care delivery?" This draft (see Appendix 6, attached) consisted of an initial page requesting demographic information from the physician. The ensuing panel meetings produced a questionnaire in which respondents are asked about their approach to diagnosis, treatment and follow-up with culturally diverse patients. The physician panelists anticipated that the responses to the questions would correspond to the level of direct experience the physician has had with that minority population, their language and culture. They agreed to complete the questionnaire themselves and assist in revising it through a subsequent panel round with the goal of having it more accurately elicit the appropriate indicators of cultural competence.

d. Determining Enrollee Ethnicity and Language

The two physician panels also devoted time to the project's objective of evaluating the methods used by both the State of California and the Federal Government in determining the racial and ethnic backgrounds of the enrollees. They were given copies of the Medi-Cal enrollment form used by the State Department of Health and Welfare, and of the Community Health Center User Survey used by the U.S. Public Health Service. As clinicians, they evaluated these forms in terms of their value in helping the health plan to signal special conditions or susceptibilities these new patients may have that would require the physician's attention. For example, the Latino panel saw benefit in knowing whether a new Latino enrollee was of African-American or Jewish extraction. The former designation would cue them to ask

questions about sickle cell anemia, while the latter would lead them to probe a patient's family history for Tay-Sachs disease.

Thus, panelists deemed the simple designation of Hispanic to be clinically insufficient. Panelists were more impressed with the group options in the federal survey. The federal survey distinguished between Mexican, Mexican-American and Chicano. Panelists argued that such designations were valuable in anticipating the level of acculturation they would likely find in their patients (i.e., Chicano represents the most acculturated to mainstream American health beliefs).

The Chinese panel was less concerned with the ethnic/race identifier designations than with the limited options for determining the principal language spoken by the enrollee. They argued that, in addition to Cantonese, the Medi-Cal enrollment form should include Mandarin, Chu-Chao and Shanghainese. Armed with this information ahead of time, they felt that clinicians would be better able to anticipate any language barriers between themselves and their patients.

III. SUMMARY OF SECOND PHYSICIAN PANELS

A. CHINESE PHYSICIAN PANEL (Second Round)

1. PATIENT SATISFACTION SURVEY INSTRUMENT

The second expert panel of Chinese physicians focused much of its attention upon a review of the draft patient satisfaction survey instrument prepared by the Latino physicians. They initially discussed the following difficulties related to conducting surveys in the Chinese population they serve. Panelists noted the following difficulties:

- 1) **Mode of inquiry.** Panelists noted that their patients tend not to respond to written questionnaires, no matter what the source. They also argued that telephone interviews have restricted usefulness due to the tendency for segments of the Chinese health plan membership to live in boarding houses. Access to the correct respondent in boarding houses is sometimes difficult. Lastly, they argued that face to face interviews tend to be the best vehicle to derive information from their members. When the issue of cost of such interviews was presented, they concluded that, though imperfect due to the limitation discussed above, phone interviews would be the next best alternative.
- 2) **Questionnaire format and tone.** The panelists noted that the reluctance of their patients to criticize their doctor made it difficult to receive from them candid responses to the provider-patient related questions. To address this problem, they suggested to phrase the questions in a more positive manner wherever possible (e.g., phrasing a question about ease of communication as "How easy has it been for you to express your medical symptoms to your doctor?" rather than "How difficult has it been..."). Secondly, they suggested using multiple questions to derive the same information. This method helps to determine the consistency of

the patients answers to similar questions (i.e., surveys of Chinese respondents should use multi-trait multi-method assessment techniques). Such evaluation of consistency helps evaluations of the genuineness of individuals' responses.

- 3) **Influence of current health and socio-economic status.** The panel expressed concern that Chinese patients would bias their appraisal of their health care according to how well they felt that day. There was a greater likelihood of negative responses to the questions if respondents felt ill when surveyed. Consequently, panelists urged the insertion of one or two questions asking respondents about their health status at the time of the interview. Panelists also cautioned that the responses of their predominately lower income patients to the survey not be perceived as typical of more affluent Chinese Americans in their area or state.
- 4) **Role of family and friends in health decisions.** Panelists questioned the assumption that a successful interaction with the patient automatically must include a family member or friend of the patient. In some instances (e.g., patients with AIDS), the inclusion of extended family or friends may prove an embarrassment to the patient and risk public exposure in his or her community. They also noted several cases of Chinese patients who lacked any such extended family or friendship network. Thus, they urged a pre-question that asks if members of the patients family or friends play a role in the respondent's health decisions.

The panel proceeded to discuss the specific questions in the draft patient satisfaction survey. In so doing they gave special attention to the following issues:

- 1) **Perception of waiting time for care.** The panelists felt that merely asking patients how long they had to wait for care was not a useful guide. This uselessness was due to tolerance for waiting to see a doctor being a relative concept for the Chinese. In Hong Kong, for example, patients tend not to make appointments, and are willing to wait long periods in the doctor's office.
- 2) **Adherence with prescribed treatment regimens.** The physician panelists thought it critical that the survey determine whether a patient was seeking alternative sources of care. They felt that it was important for the survey to inquire whether providers were capturing such information in the office visits and reacting in such a way as to keep the trust of the patient. Panelists cautioned that patients' decisions to seek non-Western treatment should not imply dissatisfaction with the Western trained doctor. Rather, normal practice for many Chinese is to seek alternative care while pursuing modern medical attention.
- 3) **Role of health plan policies and practices in responses regarding satisfaction with individual providers.** Health plan policies and procedures were discussed as a major contributing factor to patient satisfaction. The panel felt that the draft patient satisfaction survey needed to focus more questions on the interface between these plan features and the patient. Specifically, panelists were

concerned with the extent to which health plans informed the members of the full array of services available to them in a manner understandable to the limited or non-English speaking patient.

2. NEXT STEPS IN THE CURRENT PROJECT

Lastly, the panel discussed the next steps in the conduct of the current project. Panelists discussed the importance of validating the two monitoring tools developed during phase one of the project. The preference of the expert panel was to conduct direct interviews with a sample of 100 members from each of the collaborating health plan. They recommended that individuals' responses in these live interviews be correlated with the responses of their doctors on the provider self assessment scale. To allow such analysis, cluster sampling would be designed to ensure that four to five patients would complete a patient survey for each attending primary care physician in the health plan. All primary care physicians in each plan would complete the sensitivity scales, for a total of 80 primary care doctors. This would give the project a statistical power of 0.8 at an alpha of 0.05 to detect a correlation of 0.28 between the degree of patient satisfaction and the providers score on the sensitivity scale.

The Medical Director and the Principal Investigator for the project informed the panelists that the level of funding for the second phase of the grant from HRSA was insufficient to finance a cluster sample of patients of all plan primary care physicians. Given this funding limitation, the panels agreed to sample patients suffering from a single chronic condition-hypertension. Patients sampled from the CCHP will be asked to participate in telephone interviews utilizing the patient satisfaction survey instrument. Subsequently, they will be invited to participate in a focus group in which they will be asked the same questions by the facilitator to determine whether the instrument is capturing their true attitudes towards their care. The physician, in turn, will complete the Provider Cultural Competence survey and the physician information sheet. This three step process will serve to initiate the validation of the two monitoring instruments. Unfortunately, this methodology was completed only with the Chinese Community Health Plan physicians and members due to unforeseen complications in the Community Health Group's coordination of the provider survey.

B. LATINO PHYSICIAN PANEL (Second Round)

1. PANEL COMPOSITION

The second Latino Physician Panel consisted of practitioners selected from the CHG. The panel met to review the development of the patient satisfaction survey and to discuss the next steps for this project. This panel differed in composition from the first in that it included internal plan staff responsible for the coordination of clinical services in addition to the representative physicians. The group was composed of representatives from the Medical Director's Office, and from the Health Promotion and Case Management Services. Unlike the prior panel, which had emphasized individual patient-physician interaction, this panel addressed the responsiveness of plan-wide services to the needs of cultural and linguistic diverse members.

2. PATIENT SATISFACTION SURVEY

In reviewing the patient satisfaction survey draft, panelists concluded that the survey needed to address the reaction of plan members to the broader array of non-physician contacts they have with health plan personnel. Meeting this need required adding several questions and replacing others to reduce the length. The result is a draft questionnaire which seeks to assess the range of patient-health plan contacts with health plan personnel ranging from clinical staff to appointment secretaries. The contacts included member enrollment processes, access to plan benefit information and procedures, access to advice nurses, appointment making processes, and the health plan's outreach to the community in addition to direct patient care provided by physicians.

3. NEXT STEPS IN THE CURRENT PROJECT

Regarding the project's next steps, the panel expressed interest in conducting a focus group composed of health plan members. The focus groups would be charged to review the patient questionnaire for its understandability and its accuracy in capturing member perceptions of their care. Panelists also felt that it was important to restrict the distribution of the satisfaction survey to plan members suffering from one or more chronic conditions prevalent among the minority population they serve. The condition they chose was diabetes, due to its increased prevalence among the Latino population. They also chose the condition because it is highly susceptible to adherence problems resulting from patient attitudes and poor physician patient interactions.

4. CULTURAL COMPETENCE

Related input from CHG panel members and staff also further clarified the cultural competency model of primary delivery for primary care physicians treating Latino patients. Several of the panelists stressed the importance of provider cultural awareness in the treatment of Latino patients for chronic health conditions. This is due to the fact that these patients often assume a passive stance as contrasted from active participation in preventing progression or healing of their disease. The passive stance may stem from a sense of lack of control over their condition stemming from the perception that they are innocent victims of malevolent forces provoked by third parties or non-human sources. The cause of disease is sometimes related to "el mal ojo", or stigma of bad luck, placed on one individual by another. It also may grow out of a spirit of "fatalism" that one's destiny is in God's hands and not alterable by oneself (cf. above discussion).

5. THE ROLE OF TRADITIONAL MEDICAL PRACTICES

In some instances, their traditional belief system encourages Latino patients to seek the care of folk healers and or herbal cures. This is due to their perception that such individuals are in closer contact with divine forces than are conventional Western doctors. Our physicians also confirmed the findings of a study of Mexican-Americans in Texas (Chesney et al. 1980) that

Latinos often distinguish between the types of illnesses they treat with home remedies and those treatable by conventional Western medical practice. Western medical attention tended to be sought for earaches, toothaches, shortness of breath, pain in the chest, lumps in the breast, intestinal blockage, excessive urination or burning on urination, seizures, and eye problems. Folk cures, in turn, tend to be sought for fatigue, headaches, swollen ankles, nausea and vomiting, stomach pains and diarrhea. Symptoms that were handled equally as often with home remedies or medical care were loss of appetite, food and water cravings, fever, fainting, persistent cough, aching joints and skin rash.

The panelists also noted that patients could opt for folk healing cure at any time in the course of being treated by a Western physician. The fact that they seek such a course does not necessarily imply dissatisfaction with the Western trained physician, since many approach folk cures as a form of double insurance. Since most home cures employed by Latino patients cause no harm, it is critical to acknowledge and monitor their use to ensure that the patient does not substitute them for needed medical treatment.

Rather than perceiving this inclination of their patients towards traditional sources of care as a threat, the Western trained provider needs to see this as an opportunity to engender a more activist orientation in their patients. Often this involves inclusion of the patient's family members as reinforcers of physician orders. This is especially significant due to the fact that Latino patients often interpret the concept of helping oneself as being shared with one's whole family.

6. THE ROLE OF PATIENTS' EXTENDED FAMILIES

The danger of not including family and friends in treatment processes involving change in lifestyles is that family members instead may indulge the patients in being passive or encourage them to substitute home remedies for needed medical care. It is also important for the provider to appreciate the fact that members of the extended Latino family also can play an active role in the patient's health related decisions. This family can include godparents (padrinos) and close family friends (perceived as honorary uncles and aunts).

7. THE ROLE OF RESPECT

Another factor highlighted by the CHG panel and staff is the role of respeto (respect) in inhibiting the patient from asking and responding to questions of the physician. Health professionals tend to be seen by Latino patients as authority figures. Consequently, Latino patients may be reluctant either to ask questions regarding the treatment regimens prescribed by providers or to respond to life style questions for fear the doctor will feel insulted or lose respect for them. This preoccupation with respect also requires the medical practitioner to treat the patient with an equal measure of respect. This is especially true for male providers' treatment of Latina women patients, and for younger providers' treatment of older Latino patients.

8. STRATEGIES FOR IMPROVING THE EFFECTIVENESS OF CLINICAL COMMUNICATION

One remedy for the above obstacles to effective communication is the providers' establishment of personal rapport with their patients. This process tends to take a different form than it does when providers are caring for non-minority patients, for whom the commonality of culture between patient and provider often leads to a presumption that such rapport exists from the start. In the case of Latino patients, this personalistic relationship or interest in the patient as a human being has to be proven through attentive listening to the patient's concerns, by respectfully addressing the patient (i.e., by calling them Señor or Señora), and by physicians' sharing personal aspects of their lives with patients. It is interesting to note that this need for developing personal rapport with the physician is not shared by the Chinese patient population. In contrast to the Latino panel, the Chinese physician panel argued that respect was much more important to their healthy interaction with patients, and that sharing of personal details did not increase that respect. The Chinese panel felt that personal informality was not consistent with respect in the minds of their patients. These differences highlight the facts that each racial or ethnic group poses different challenges to the creation of effective interaction between patients and providers, and that the typical dynamics of the interactions differ between these ethnic groups. These unique dimensions need to be accommodated for in a legitimate culturally competent model of health care delivery.

IV. PATIENT SATISFACTION SURVEY INSTRUMENT

A. OVERVIEW AND DEVELOPMENT PROCESS

The patient satisfaction survey was developed in response to the need for an instrument to monitor the quality of care provided by managed care plans contracting to serve limited and non-English speaking enrollees from culturally diverse ethnic or racial backgrounds. In California, this need has been highlighted by the decision of the State to require the use of such a culturally oriented tool for monitoring of all private Medi-Cal managed care contracts with the State effective in early 1996.

The Physician Panels were asked to focus on this as their first assignment. In the case of the CHG, a written patient satisfaction survey already was in use by the Plan. However, this survey instrument lacked the scope required for the State programs. In addition, it made assumptions about the Plan's provision of culturally competent health care delivery based on the fact that the core of their physicians were bilingual Latino health care providers. In the case of the CCHP, the Plan had not utilized a formal plan-wide means of discerning patient satisfaction. This was due to the fact that CCHP had found its Chinese enrollees to be unreceptive to returning written questionnaires, while the expense of extensive phone interviews was too costly for the Plan. In contrast, the Latino physicians found relatively less problems with the use of written patient surveys.

The Patient Survey instrument was developed by the Chinese and Latino physician panels in a series of meetings. Between the two physician panel meetings, individual panelists reviewed drafts of the survey instrument which incorporated the modifications suggested by members of

the other panel. By the conclusion of their second sessions, both panels were able to agree on the possibility of establishing a single instrument for assessing patient satisfaction. This agreement on a single instrument should not be taken as implying that panelists thought that there were no inter-group differences in survey techniques, in traditional health beliefs and practices, or in surveying techniques. Panelists did identify differences between traditional Latino and Chinese health beliefs and practices. In addition, panelists thought that a written survey instrument could be used with Latinos, while telephone interviews were thought by the Chinese physicians to be the technique likely to gain the greatest response from Chinese. The subsequent Chinese patient panel, in contrast, expressed more support for the appropriateness of written surveys. Both panels also noted the problem illiteracy poses for the use of written surveys in their communities. When the option of illustrated questionnaires was suggested to them (e.g., the Dartmouth Coop Survey), several of the panelists felt such instruments would be perceived as demeaning and culturally irrelevant to their patients.

Both Latino and Chinese panelists thought that the survey instrument developed in this project and included below could be used with minor revisions with members of either community when translated into the appropriate language. The development of this Patient Survey instrument also was perceived by both panels as a useful exercise which brought to light a number of issues relating to the use of such surveys in minority limited or non-English speaking populations.

It was anticipated that the panelists would have the opportunity to evaluate the appropriateness of other patient satisfaction surveys used by commercial health plan providers in California with minority patients. This, however, proved not to be possible, due to delays in the State of California's receiving such documents as part of the Medi-Cal managed care contract review process. Nonetheless, access to other non-commercial surveys was facilitated by the project's external consultants. Specifically, the instruments prepared by the University of California, San Francisco and used with their clinic patients proved most helpful to the project team in revising the initial draft instruments prepared with the panelists.

Following is a question by question summary of the meaning and intent of the panelists and project team in designing each of the questions comprising the patient survey. The determination of what exactly constitutes a favorable response will await the completion of a full validation of the monitoring instruments to be completed in a follow-up study. It should be noted that each of the study sites independently made slight adjustments to the survey instruments used with their members. This has led to slight discrepancies between the question numbers listed below and the question numbers in this pilot test of the patient satisfaction survey instrument. The patient satisfaction survey instrument is included as Appendix 2 at the end of this report.

B. QUESTION-SPECIFIC MEANINGS AND INTENT OF PATIENT SURVEY**Questions 1, 2: Health plan membership and duration of membership**

Enrollment information will likely capture the answer to this question with some pre-determined code. If so, this question may not be necessary. It does, however, bring up the question of confidentiality in use of such surveys. Since the results of the patient survey are to be correlated with the ethnic/racial background and language proficiency of the enrollee, confidentiality is inherently compromised. It is further compromised by the fact that outcome studies by ethnic/racial groups are to be required of health plans by the new Medi-Cal managed care regulations. To the extent that patient satisfaction can be correlated with these outcome data, the State and the Plan will have a more precise understanding of the quality of care provided to ethnic and racial minorities in the plans.

Question 3,4,5: Health status and use of Plan clinical services

Questions 3 and 4, asking the individual's health status, were suggested by the Chinese Panel. They felt that their patients' perceptions of the treatment received from their physician and health plan was influenced greatly by how well they felt at the time they were asked. Hence the question of health status would help to qualify the nature of the responses received in a patient survey targeted at Chinese and possibly other groups as well. Initially, our project had intended to provide a more in depth health status inventory to accompany the patient satisfaction survey. The panelists discouraged us from this undertaking, arguing that culturally diverse populations tend to have very subjective and idiosyncratic ways of perceiving and describing their health conditions. Specifically, Chinese patients tend to focus on a single relatively minor symptom rather than discuss the full importance of a serious condition. With respect to Question 5, the physician panels argued that a patient must have experienced care from the plan in order to offer an informed opinion of the quality of care he or she is receiving.

Questions 6,7: Language fluency

These questions are designed to determine both the language most often used and the level of English language usage by the patient as one determinant of his or her level of acculturation and comfort with mainstream health care practices. These questions are also designed to screen respondents for the ensuing series of questions on translator services and communication with their providers.

Questions 8,9,10,11: Plan interpreter services

The reliance on interpreters to communicate with limited English speaking patients is necessary for most health plans lacking in sufficient numbers of providers fluent in foreign languages. Thus, the use of an interpreter is not necessarily an indication of poor quality care. The lack of preparation of such interpreters and the degree to which plans rely on potentially biased communicators such as family members and friends may be indices of questionable quality of care. The panelists, for example, observed that family members may try to shield their loved ones from information transmitted by the doctor on the patients' conditions and/or treatment.

Question 10 seeks to determine the extent to which the health plan is providing interpreter services for a range of service contacts. This list was conceived by the administrative staffs of both CHG and CCHP.

Questions 13,14,15,16,17: Delays in receiving care

These questions are general satisfaction questions designed to provide an overall perception of the enrollee's level of satisfaction with their physician and the health plan. In designing the question relating to satisfaction with the length of time spent waiting for an appointment, the panelists accommodated for the different perceptions of time in different ethnic or racial communities. Consequently, the question does not specify a range of times to choose from, but leaves it to the respondent to answer the question based on their perception of what is acceptable.

Questions 12,18,19,20: Access to linguistically competent care

These questions seek to determine whether health plans are successful in educating the limited English speaking enrollees on how to access their doctors for answers to their questions. These questions also examine the plans' abilities to link these patients with relevant health plan services, and with providers who speak their language.

Questions 21,22,23,24: Adequacy of communication

This set of questions explores the respondents' perceptions of the ability of their doctors to communicate with them and listen to them. These questions address communication around the diagnosis and the treatment, since the panelists believe a clear discussion of both with the physician is a precondition for ensuring appropriate adherence by the patient with care. The specific reasons for this poor communication may range from doctor induced causes, such as rushing the patient, to patient centered causes, such as personal embarrassment. Yet, even these latter explanations can be overcome by a provider who is capable of establishing a cultural and personal rapport with the patient.

Questions 25,26,27: Prescribed medication regimens

These questions are designed to determine how familiar the patient is with his or her medication regimen. Specifically patients are asked to recall the name of the drugs which have been prescribed for them, the condition for which each is intended, and the instructions for its use. A patient's inability to answer these questions may suggest the provider's failure to communicate effectively with limited English speaking patients. We anticipate using these questions in evaluating the significance of the provider survey.

Questions 28,29,30: Understandability of medication instructions

These questions on the instructions provided on medication bottles grew out of the Chinese patient panel discussions. They believed that health plans should ensure that medication instructions on labels be offered in the patient's dominant language and or that pharmacists review personally with the patient the use of the prescribed medication.

Questions 31,32,33: Family role in care decisions

These questions relate to the provider's awareness of the role family members and friends frequently play in health decisions of patients from diverse racial and ethnic backgrounds. Failure to acknowledge this family involvement can lead a physician to ignore the role of extended family and friends in reinforcing or sabotaging a regimen of treatment. An example of this is the primary role of the Chinese grandmother in the health decisions affecting many Chinese infants.

Questions 34,35,36,37: Factors affecting adherence

These questions are intended to determine whether the patient is experiencing difficulty in understanding and following the treatment instructions of the physician. To the extent that communication problems exist among a provider and the patient, this is where its consequences are likely to become apparent. Other factors can also impinge on adherence. These include side-effects, and the duration and costs of treatment. To the extent that physicians prepare patients for potential side effects, the limited English speaking person is more likely to adhere to the prescribed treatment regimen.

Questions 38,39,40,41: Use of alternative sources of care

This set of questions addresses the practice of some minority patients of seeking alternative sources of health care outside of their health plans. These other sources may range from folk healers and home remedies to other western trained health care providers. It is not uncommon for minority health plan members to utilize the services of a more culturally familiar community clinic in preference to the health plan's services. However, such an inclination to go outside the plan may not always indicate dissatisfaction with the physician and the health plan. Thus the related questions seek to probe the specific reason for such a course of action.

Questions 42,43,44,45: Overall levels of satisfaction

These final questions are aimed at identifying the respondents' overall levels of satisfaction with health plans. The panelists thought these overall questions should follow the more targeted questions in order to elicit more thoughtful responses to the general satisfaction questions. The respondents also are given the opportunity to revisit any specific health plan limitations and give specific open ended suggestions for bettering the quality of care they receive from their plan.

C. PILOT STUDY RESULTS

The patient satisfaction survey was pilot tested in samples of 75 patients each from CHG in San Diego and CCHG in San Francisco. All sampled patients were hypertensives who had made at least three physician visits in the prior year. Statistical tables presenting the results from these pilot surveys are readily available on request.

Review of results from the conduct of the pilot test of the Patient Satisfaction Survey guided the investigators in drafting changes to the original draft of the survey format used in this

project. These changes reflect the insights resulting from:

- 1) **An analysis of the responses received to each of the questions in light of the relevance of the questions to the respondent and the goals the survey was designed to meet.** The patient satisfaction survey was initially conceptualized as a "screening" study. That is, the study was initially designed to indicate areas which potentially involve problems resulting from patients' linguistic and/or cultural backgrounds. The study was not designed to confirm specific hypotheses (i.e., "diagnoses") regarding the roots of any problems which are found. Most confirmatory questions also elicited relatively few responses. Those confirmatory questions which elicited few responses were either rewritten or dropped from the survey;
- 2) **The associations of the responses to the Patient Satisfaction Survey with responses to the Provider Cultural-Competence Self Assessment.** One major goal of the Provider Cultural-Competence Self-Assessment was to predict responses to the Patient Satisfaction Survey. Attempts to evaluate this predictive validity had only limited success. The two survey formats were initially designed in consultation with different groups, and were not designed to be consistent with each other. Questions in both survey formats have been altered to make the survey formats more consistent with each other (The original questionnaire formats are attached as **Appendices 2 and 3**. The revised questionnaire formats are attached as **Appendices 5 and 6**). This increases inter-consistency and will facilitate conduct of the analyses needed to evaluate predictive validity; and
- 3) **The comments of telephone interviewers regarding certain difficulties they faced in administering the survey.**

The following are the major revisions made to the original draft and the reasons for those changes.

- Q7. **"How well do you communicate with your doctor in English?"** This question was revised to ask **"How do you usually communicate when receiving medical care?"**, followed by a list of six possible responses. This reformatting was designed to capture more precisely the nature of doctor-patient communication. It will also be used to direct those responders who use English to communicate with their doctors to skip the ensuing nine questions, all of which relate to interpretation services.
- Q13 **"Have you ever...not asked the question due to your concerns about communication difficulties?"** This question was added to be consistent with provider Q5.
- Q14 **"Have you ever had to wait more than two days to see a Plan physician for an urgent condition?"** Questions 14-17 ask about delays receiving care for "urgent" conditions. Chinese respondents had difficulty understanding the term "urgent condition". Questions 14-17 have been reworded to ask about delays receiving care **"for a condition you feel requires immediate attention"**. The two day threshold in Question 14 resulted from the physician panels' determinations of unacceptably long waiting times

1. for certain urgent conditions, and the patient panels' sense of what they considered intolerable waiting times for such appointments.
- Q20** "If you have never called your doctor...do you know how to call your doctor?" Respondents and Plan physicians viewed this as an unnecessarily curtailed reason for failures of patients to contact their doctors. This question has been redrafted to ask "If you have never called your doctor...why didn't you call?" with a list of seven possible responses. This rewording and the list of responses are designed to gain clarity regarding patients' perceived reasons for not calling their physicians.
- Q22** "Communication difficulties" These two questions were dropped both because they elicited few responses in the pilot survey, and because the newly reworded Question 20 captures much of what these questions were intended to target. Question 23 regarding physician repetition, and Question 24 inquiring about physician requests for patients to repeat physician instructions have been added. These questions are designed to ask about well accepted techniques of increasing patient understanding and adherence. They are consistent with newly added questions in the provider survey which explore competence in cross-cultural communication.
- Q31** "Does the pharmacist...explain the instructions for taking prescriptions?" This question has been reworded into Question 31 of the revised survey: "If the instructions are hard to understand,..." The question has been reworded to avoid responses regarding instructions for medications for minor problems such as colds which typically do not involve complicated instructions. Question 32 has also been added "...how often does your doctor ask you to bring in the pill bottles...?" This new question asks about a well accepted technique for monitoring adherence. A similar question was also added to the provider self-assessment as Question 18f to examine both provider awareness of techniques for monitoring adherence and the consistency of patient and provider responses.
- Q38** "Have you used any of the following sources of care outside the health plan?" This question has been reworded as Question 43 of the revised survey. The question seeks to identify the alternative health practitioners who have been servicing the brunt of the demand resulting from each Plan's inability to satisfy the health care wishes of its enrollees. The list of possible responses has been condensed to capture the alternative sources reported in the pilot survey while simplifying the respondents' task. Question 39, "...why did you choose this source of care?" has been dropped because it elicited few responses in the pilot survey.
- Q40** "If you used alternative sources of care, did you share this with your doctor?" This question has been reworded as Question 44 of the revised survey to apply only to those with serious conditions for whom the sharing of such information is likely to be clinically more significant. This question is designed to be consistent with Question 10 of the provider self assessment. The consistency will allow investigation of the predictive validity of provider Question 10. Question 45 asks how the doctors responded to the information that the patient was using alternative sources of care. This latter question was written to be consistent with provider Question 13. This consistency will also allow

the evaluation of predictive validity.

V. PROVIDER CULTURAL COMPETENCE SELF-ASSESSMENT

A. OVERVIEW AND DEVELOPMENT PROCESS: PROVIDER CULTURAL COMPETENCE SELF-ASSESSMENT

The Provider Survey is a product of the Latino and Chinese physician panels at CHG and CCHP respectively. After the initial panel meetings, the project team prepared a draft of the self-assessment instrumentation to all panel members. Following their review and revisions by individual panel members, a final draft was prepared for review by the team of project consultants. These included Dr. Ka Kit Hui of UCLA School of Medicine, Dr. Eliseo Perez Stable of the University of California at San Francisco Medical School, Dr. Arthur Chen of Asian Health Services in Oakland, Roberto Velasquez, Ph.D. of the Behavioral Health Group, and Howard Barkan, Dr.P.H., independent consultant.

The Provider Survey is intended for use by physicians and other health care providers as a self-administered assessment tool. With this instrument, the provider should be able to determine the extent to which he or she could benefit from additional training in meeting the challenges posed by patients from diverse language and cultural backgrounds. While most questions in this survey are investigative, many also have an heuristic intent. These questions seek to increase respondents' awareness and, hopefully, by extension their cultural competence. Questions with an heuristic intent have been identified in the following discussion of question specific meanings and intent. After review of findings from the current, pilot study, the questions in both the Patient Satisfaction and Provider Cultural Competence surveys have been redesigned to allow investigation of the associations between patient and provider responses to parallel questions. These redesigned survey formats are attached as Appendices 5 and 6.

In designing this instrument, the project team was conscious of the need to differentiate between cultural competence and cultural sensitivity. As discussed above, the former refers to a set of skills based on knowledge gained through broad experience or through training in treating such patients. The latter refers to a psychological propensity for appropriately treating such patients, even though one may lack actual relevant clinical experience with such populations. The purpose of this tool is to assess cultural competence, not sensitivity. It is designed to identify whether the provider has a level of knowledge-based competence consistent with a minimum level of experience and training in working with such patient populations. Thus, the instrument can assist health care providers in determining whether they might benefit from such training and/or additional exposure to this type of clinical practice. The State of California also is contemplating requiring managed care health plans to provide such a Provider Self-Assessment instrument in order for those vying for Medi-Cal contracts to receive bonus points. The Provider Cultural Competence Self-Assessment is included as Appendix 3 at the end of this report.

B. QUESTION-SPECIFIC MEANINGS AND INTENT

Following is a question by question summary of the meaning and intent of each of the questions comprising the provider survey. While the actual determination of what constitutes an appropriate response to each question awaits the completion of a subsequent validation study, the ensuing summary describes the rationale behind each question.

Question 1: Group-specific disease prevalences

The objective of this question is to determine the degree to which the provider is familiar with diseases particularly common in ethnic and racial minority communities in this country. Respondents are asked to associate specific diseases with those corresponding minority populations which most suffer from each illness. The physician panels identified certain diseases as being among the most prevalent with Latinos (i.e., cervical cancer, tuberculosis, diabetes) and others as being highly prevalent among Chinese (i.e., G-6PD deficiencies, liver flukes, intestinal parasites, thalassemia, hepatitis B and nasopharyngeal cancer).

Question 2-3: Comfort caring for limited English speaking patients

These questions seek to determine the provider's comfort levels with treating limited English speaking minority patients in primary care settings. They focus upon the treatment of chronic health conditions such as diabetes mellitus, asthma, and hypertension. These conditions were determined by both panels to be challenges in treating patients from their communities.

Question 4: Responsibility for caring for limited English speaking patients

This question seeks to identify the provider's perception of where the responsibility lies for the care of non-English speaking patients. A willingness to place primary responsibility on non-clinical health plan staff would be an indication of an inability to come to terms with the provider's primary obligation to coordinate the care of these individuals. This question is intended to determine the degree to which the individual provider accepts personal responsibility for ensuring that the culturally diverse patient is being treated in an appropriate manner. To the extent that respondents see the responsibility for culturally appropriate care to rest solely with non-clinical health plan staff, one can assume the providers are not acknowledging the importance of their role in guaranteeing the cultural competence of those involved in providing such care.

Question 5: Potential barriers to physician-patient communication

This question seeks to determine whether providers are sensitive to their role in promoting maximum communication between themselves and their limited English speaking patients from diverse cultural backgrounds. To the extent that the respondents understand the role of "respect" in these patients relations with them as authority figures, to that extent the respondents will find it easier to understand the inhibitions these patients face either in asking questions or sharing information with the physician.

Questions 6,7,8,9: Interpreter services

These questions aim at the respondents' understanding of the potential danger in over-reliance on interpreters to communicate with non-English speaking patients. These dangers include subjective interpretation of what was said, inaccurate transmission and/or omission of what was actually said by the patient. One mechanism to double-check the interpretation is to ask from time to time more than one question seeking to derive the same information. The respondent also should acknowledge the importance of meeting regularly with those that interpret for them to discuss communication issues regarding their patients. Where a provider has limited knowledge of a patient's language, he or she should seek to communicate informally with the non-English speaking patient in that language. Lastly, wherever possible, providers should avoid the use of children or family members in serving as interpreters due to the potential for distortion in the responses and potential emotional stress to children.

Questions 10,11,12,13: Traditional health beliefs and practices

These three questions seek to identify whether the respondent is alert to the importance of traditional health beliefs and behaviors for patients from cultures which practice non-Western forms of health care. One of these beliefs is the tendency for patients from certain minority cultures to connect mind and body closely. Such connection can result in a greater degree of somatization by these minority patients compared with mainstream Caucasian patients. These questions have an heuristic intent. They also attempt to identify the level of tolerance which the provider has toward such practices. Feelings of anger and hostility toward patients who hold such beliefs can only undermine the ability of physicians and patients to communicate effectively with each other.

Question 14: Patient adherence to prescribed regimens

This question relates to a provider's knowledge of the distinct elements which may complicate a limited English speaking patient from a diverse cultural background's ability to adhere to prescribed treatment regimens. Our physician panels suggested that many of their culturally diverse patients tend to lapse in their adherence to the treatment they were prescribed when faced with diseases devoid of clear symptoms. This tendency calls for physicians to be more attentive to the adherence of these patients than would be the case for English speaking patients with mainstream health beliefs.

Question 15: Quantities prescribed

This question addresses the need for physicians to monitor closely limited English speaking patients' adherence to their prescribed medication regimens. This question has an heuristic intent. One method of achieving increased adherence is for physicians to prescribe smaller amounts of the medication. Where the potential for non-adherence exists, this prescribing of smaller amounts encourages patients to meet more frequently with doctors.

Question 16: Group-specific frequencies of medication side-effects

This question seeks to discern whether the respondent understands the potential for unanticipated reactions on the part of minority patients to types and dosages of medications normally prescribed to Caucasian patients for the same disease. This question has an heuristic intent. The acknowledgement by our two panels of such potential disparate reactions is corroborated by the findings of the National Pharmaceutical Council regarding ethnic and racial minorities responses to antihypertensive drugs and psychotropic agents among others (Richard Levy, Ethnic and Racial Differences in Response to Medicines, National Pharmaceutical Council, 1993). Our panelists also acknowledged that many practicing minority physicians are likely not to be able to specify the differential responses of their patients to a range of medications. This only corroborates the value of this survey both for minority and non-minority providers.

Question 17: Patient expectations regarding physician actions

This question aims to identify whether providers understand that minority patients from culturally diverse backgrounds frequently expect immediate treatment (e.g., injection, prescriptions) during the office visit, and may be unreceptive to prolonged treatment regimens, especially those involving agents with side-effects. They also exhibit a tendency to perceive treatment the same as a cure. This also may result in increased frustration with their physician inability to produce immediate results and a consequent desire to switch doctors.

Question 18: Strategies to improve patient adherence

This question seeks to identify whether the respondent is aware of certain practices which can enhance minority patients' adherence to their prescribed treatment regimens. These practices include the use of "indirectas", or indirect messages which seek to elicit patients' involvement in the process of seeking their cure ("I want you to help me so that I can help you"). The Latino panel found this approach to be especially useful with their patients. Another practice this panel identified as very helpful was connecting in the patient's mind the importance for their family of taking care of their own health. They also identified the value of using colloquial expressions in the patient's language to demonstrate the provider's respect for the former's culture and language.

C. OVERVIEW AND DEVELOPMENT PROCESS: PROVIDER CULTURAL AND ETHNIC BACKGROUND

The questions are intended to identify the cultural and linguistic backgrounds of the respondent providers, and to describe their level of experience interacting with limited English speaking individuals. During the next phase of this project, the associations of these background characteristics with responses to the self-assessment survey will be explored. Evaluation of these associations have implications for the prevalent hypothesis that cultural competence is predicated on the providers sharing his or her patients' ethnic and/or racial background. Further studies of predictive validity could explore the associations of these sets of responses with patient adherence to prescribed medication regimens, with use of clinical services, and with clinical health status outcomes.

D. PILOT STUDY RESULTS

The Provider Cultural Competence Self Assessment was initially designed to be a self-diagnostic tool for practitioners. This self-assessment was pilot-tested with 54 physicians from the CCHP. Statistical analyses of the results are readily available on request.

Changes have been made for the same reasons that changes were made in the Patient Satisfaction Survey: i.e., to eliminate confirmatory questions which elicited few responses and to increase the inter-consistency of the two surveys. The revisions also seek to complement the original, knowledge-based questions in the self-assessment with questions that clarify the providers' and the patients' perceptions of what is occurring in their interactions with each other. Examining the strengths of the associations among patient and provider responses to parallel questions will indicate more clearly how effectively each is communicating with the other.

The following are the principal changes made in the original provider self-assessment surveys pilot-tested with physicians from the Latino and Chinese health plans.

- Q4 **"Primary responsibility for...adequate care for non-English speaking patients..."**
This question has been dropped. When used with actual health plan physicians, it was found to be too obvious. It was consequently of little value in evaluating cultural competence. Questions 4 and 5 have been added. These questions ask about patients' blocked desires to ask questions and frequency of asking questions. They parallel Question 13 in the Patient Satisfaction Survey. The accuracy of physician responses to Questions 4 and 5 can be tested by examining their associations with their patients' responses to Question 13.
- Q6 **"How do you test the quality of interpretation?"** This question has been divided into Question 6 on the revised self-assessment, which asks the same question, and Question 7, which asks **"Which strategies are effective in improving the quality of direct communication..."** This latter question both consolidates the original Questions 7 and 8 and adds to the strategies listed in the original assessment. These questions are consistent with Questions 35-37 of the revised Patient Satisfaction Survey. The accuracy of physician responses to these questions can be evaluated by examining their associations with the appropriate patient questions.
- Q14 **"Relative adherence rates of English and non-English speaking patients."** This question has been dropped because respondents to the pilot survey found the answer to be too obvious. It has been replaced with a new Question 14: **"What percentage of your limited or non-English speaking patients adhere to virtually all of their prescribed treatment regimens?"** This new question has been designed to be consistent with Question 39 in the revised patient survey. Question 16 has also been added, asking the physicians to report the frequencies with which they advise their patients of possible medication side-effects. Question 16 was designed to be consistent with Question 41 on the revised patient satisfaction survey. The accuracy of physician and patient responses can be evaluated as outlined above for other questions.

Q18 "When giving a prescription...how effective are...the following approaches in maximizing adherence?" This question has been revised to refer directly to the act of writing a prescription. This revision is designed to focus the physicians on the specific activity (i.e., writing a prescription) as it relates to the process of maximizing adherence. The listed possible responses to this question have been expanded to include the additional optimal responses identified over the course of the pilot survey. Questions 24, 32, and 37 have been added to the patient survey to make that survey more consistent with strategies listed in this question on the Provider Cultural Competence self-assessment.

These changes in the two survey instruments lay the groundwork for the use of the Patient Satisfaction Survey and the Provider Cultural Competence Self-Assessment as linked diagnostic tools with which to assess providers' knowledge and skill in caring for limited and non-English speaking patients. The pilot testing of these instruments offered only a few opportunities for examining the viability of associating the responses to the one instrument with the responses to the other (cf. Section VI, below).

A full pilot test of these two revised instruments will await a second follow-up study to this HRSA funded project. In that next phase, patients will be sampled in clusters receiving care from particular primary care physicians. Linkage of physician and patients will be maintained in the data set. The associations between patient and provider responses will be explored in analyses of the linked data sets. The strengths of these associations will indicate the predictive validity of responses to the Provider Cultural Competence Self-Assessment for patient responses to the Satisfaction Survey. In addition, each provider completing a self-assessment will receive a written report detailing the provider's apparent strengths in delivering culturally competent care, and those areas in which he or she still needs improvement.

E. COMBINED ANALYSIS OF PATIENT SATISFACTION SURVEY AND PROVIDER CULTURAL COMPETENCE SELF-ASSESSMENT

As noted above, it was possible to examine the associations between a number of questions asked on the pilot patient and provider surveys. Available data allowed the exploration of the associations for two questions: the mutual understandability of the languages spoken by the patient and the physician, and physician direct contact and communication with patients' families.

Unfortunately, aspects of the organizations in which the pilot survey was conducted have limited the combined analyses which could be conducted. CCHP is an HMO organized in San Francisco's Chinatown to serve a primarily Asian patient population. Almost all providers in that HMO speak Chinese. This resulted in the physicians being able to speak the native language of almost all of their limited and non-English speaking patients (table readily available on request). As such, it was not possible to explore the association between physician-patient linguistic compatibility and patient satisfaction.

All responding physicians rated direct communication with patients' families as effective or very effective in maximizing adherence (Question 15D). However, all but one responding

patient reported that their physician never talked with family members. This may indicate a substantial difference between explicitly stated physician strategies and actual provider actions. However, the physicians were not asked in the pilot survey how often they actually talked with patients' families. Direct comparison of physician and patient responses was thus not possible. As noted above, the provider self-assessment has been altered to allow such direct comparison of responses.

VI. ETHNIC IDENTIFIERS AS CUES FOR THE PROVISION OF CULTURALLY COMPETENT HEALTH CARE

The use of ethnic self-identification forms in the enrollment of Medi-Cal (i.e., Title XIX) beneficiaries is an issue of growing concern for both state Medi-Cal agencies and national entities seeking to monitor quality assurance among target populations (e.g., the National Council on Quality Assurance). Their concern emanates from two issues. The first issue is the need to ensure that the managed care systems with which they contract and which they monitor will have a vehicle which they can use to determine the specific needs of the culturally diverse beneficiaries they will serve upon enrollment. The second issue is that accurate identification of enrollees' ethnic or racial backgrounds will facilitate monitoring of health outcomes for subgroups within the health plans.

A large body of literature exists which ties health related attitudes and behaviors of individuals to their level of acculturation. The inverse question of how the absence of acculturation affects health behaviors and attitudes has been less studied. Key to exploring this dimension is the capacity to distinguish between behavioral ethnicity and ideological ethnicity. The latter relates to individuals' identification with an ethnic heritage. This allegiance, however, may not affect individuals' daily actions or their attitudes and outlook on health and illness. Behavioral ethnicity, in contrast, involves the ethnically specific health attitudes and behaviors of individuals. Buchwald et al. note that the importance of behavioral ethnicity stems from the fact "their attitudes and outlook on health and illness are likely to clash with those of the biomedical perspective" (1994: 113).

If the potential for this clash exists in the relation between a patient and their health provider, the ability to predict such behavior would be very beneficial for a health plan interested in serving the needs of limited or non-English speaking enrollees. The early identification of individuals with such attributes can help the health plan prepare to serve Medi-Cal and other new enrollees from diverse linguistic and cultural backgrounds. These are the conclusions of our two Physician Panels representing the two managed care plans in our project. They believe that such advance warning of behavioral ethnicity is most beneficial to health maintenance organizations in planning for the provision of culturally competent providers, interpreters, health plan forms and telephone access in target languages. Consequently, they believe a mechanism to identify these potential target enrollees needs to be incorporated in the initial enrollment process.

What can be done to predict the presence and consequences of such behavioral ethnicity prior to enrollment? Recent research on medical interviewing techniques has identified several predictors of behavioral ethnicity (Johnson, Hart, et al., in Lipkin, Putnam, and Lazare 1994).

The following have been identified as predictive of behavioral ethnicity:

- 1) **Emigration from a rural area;**
- 2) **Frequent returns to the country of origin;**
- 3) **Inexperience with Western biomedicine;**
- 4) **Lack of, or limited formal education;**
- 5) **Little knowledge of English;**
- 6) **Low socio-economic status;**
- 7) **Major differences in dress and diet;**
- 8) **Recent immigration to the United States at an older age; and**
- 9) **Segregation in an ethnic community.**

Johnson, Hart, et al. argue that socio-economic status more than any other single item accentuates the presence of behavioral ethnicity in an individual's attitudes and behavior. Since low income status is a given for Medi-Cal enrollees, the Panels felt that the next important identifying variable was enrollees' knowledge and use of English. They concluded that questions relating to language use on the health plan enrollment form for Medi-Cal beneficiaries are the most useful supplement to a basic ethnic self-identification question.

In contrast, the most common mechanism for identifying applicants' ethnicity which is now in use by the Federal Government and State agencies is the simple ethnic identifier question. An example of this is the OMB Community Health Center User Survey, which asks "What is the group or groups which represents your race?" This approach has primarily sought to collect data useful in determining eligibility for government programs. Questions of this type have not been designed to generate information which can alert health care providers to the needs of minority patients. In order to standardize the classifications used to determine race and ethnicity, the federal government has sought to base its rules for classification into racial and ethnic categories on four defining features (Office of Management and Budget Directive, No. 15). These are:

- 1) **Descent from the original peoples of a specified region;**
- 2) **A specific cultural origin;**
- 3) **Cultural identification or affiliation; and**
- 4) **Race.**

Unfortunately, these features do little to highlight the presence or absence of behavioral ethnicity.

This ambiguity is further aggravated by the directive's failure to clarify whether self-declaration or determination by an interviewer is the preferred mode to derive such data. Another confounding factor in the use of self-identifiers is the respondent's frequent confusion over the terms used to denote ethnic or racial sub-groups. In the 1980 Census, for example, over 40% of the persons who classified themselves as Hispanics answered "other" instead of "white". This was due to the fact they perceived "white" as referring to Anglo descent (Hahn 1992).

In the case of the various states, the Report of the Secretary's Task Force on Black and Minority Health, pointed out that not all states collect ethnic identifier information. Those that do often fail to use consistent methods. Such is the case with the State of California. The Medi-Cal Program enrollment forms vary from those used by the State's Department of Health Services (DHS) for health statistics. Cognizant of the need to redesign the race/ethnicity data collection, coding and reporting process, the State's Family Health Outcomes Project has developed recommendations for possible implementation in all DHS programs. These include the following:

- 1) **Data collection forms should be uniform across all DHS programs;**
- 2) **Data collection practices should be consistent with federal decennial census and National Center of Health Statistics methodology;**
- 3) **Data should be collected via self-declaration;**
- 4) **Data collecting should ask a separate other question on Hispanic/Latino origin besides the categories of Mexican, Mexican American, Chicano, Puerto Rican, and Cuban; and**
- 5) **Programs serving children should collect information on mother, father and child's race/ethnicity and country of birth.**

In addition, the California Governor's Office has issued an Executive Order (W-110-94) which requires all Executive Branch departments collect and report data on Asian-Pacific Islanders as a distinct group. The State's current statutes also call for distinct identification of the following categories: Asian Indian; Cambodian; Chinese; Filipino; Guamanian; Hawaiian; Japanese; Korean; Laotian; Samoan; Vietnamese; Other Asian; and Other Pacific Islander.

The current Medi-Cal enrollment form differs from other state forms in one critical way. It asks the enrollee to identify what primary language he or she speaks. Enrollees have the option of choosing from among the following: Spanish; English; Cambodian; Cantonese; Vietnamese; Lao; Tagalog; American Sign; and other. Unfortunately, the proposed State recommendations do not include a requirement to determine the predominant language spoken. Both panels strongly supported the importance of preserving this element in State and federal health related data collection. The Chinese Panel did express concern that the language category for respondents of Chinese descent be broadened beyond Cantonese to include Mandarin and other Chinese languages.

The failure to include questions on language(s) spoken and level of education call into question whether those federal and state government data collection methods which collect only race and ethnicity data are sufficient to forecast the need of a specific enrollee for culturally competent health care services. Currently, few managed care health plans in California ask for information on racial or ethnic identity in the process of enrolling their beneficiaries. Nor are the current enrollment data collected primarily by local county welfare personnel being transmitted to the health plans contracted to deliver MediCal Managed Care. This lapse in third party transmission of ethnic data is occurring despite the State of California's expectation that these contracting HMO MediCal contractors utilize such designations for the purposes of determining if a minimum threshold exists anticipating the need to plan for the quality of care provided to culturally and linguistically diverse minority enrollees.

In light of the limitations of current state and federally administered ethnic identification mechanisms described above, it is essential that these governmental entities collect and transmit existing health related data collection of indicators of behavioral ethnicity such as languages spoken and level of formal education. A continued reliance on instruments which capture only ideological ethnicity may inhibit the Medi-Cal contracting health plans' preparation for culturally diverse enrollees and the government's monitoring of the quality of care they receive.

It is imperative that additional data on the health status of ethnically and culturally diverse Medi-Cal beneficiaries be obtained at the time of enrollment. This minimal health status inventory should include immunization data and information on whether a female beneficiary is pregnant in order to anticipate the pre- and perinatal needs of these new enrollees. Another need is for the enrollment form to permit beneficiaries with large families to denote all the primary care physicians currently caring for their members instead of the current limit of two physician responses per family.

Buchwald D, Caralis P, Gany F, et al. "Caring for patients in a multi-cultural society, Patient Care" 28 (June 16, 1994):105-120.

Dumbauld S, McCullough J, Sutocky J Analysis of health indicators for California's minority population, State of California, Department of Health Services: 1994.

Gill PS, Johnson M Ethnic monitoring and equity , BMJ 310 (April 8, 1995): 890.

Hahn RA "The state of federal health statistics on racial and ethnic groups", JAMA 267 (1992):268-271.

APPENDIX 1

KNOWLEDGE, SKILLS AND ABILITIES ESSENTIAL TO CULTURAL COMPETENCE IN PRIMARY HEALTH CARE

KNOWLEDGE

- Knowledge of the culture, history, traditions, values, and family systems of ethnic minority patients
- Knowledge of the impact of class and ethnicity on the health status, behavior, attitudes, and values of patients
- Knowledge of the help-seeking behaviors of ethnic minority patients
- Knowledge of the roles of language, speech patterns, and communication styles in ethnically distinct communities
- Knowledge of the impacts of social and health plan policies on ethnic minority patients
- Knowledge of the resources (e.g., agencies, persons, and helping networks) which can be utilized on behalf of ethnic minority patients and communities
- Recognition of the ways in which professional values may conflict with or accommodate the needs of ethnic minority patients

SKILLS

- Personal qualities that reflect genuineness, empathy, warmth, and a capacity to respond flexibly to a range of possible situations
- Acceptance of ethnic differences between people
- Explicit understanding of the health care providers' personal values, stereotypes, and biases about their own and others' ethnicity and social class
- Techniques for learning and adapting to the personal and cultural patterns of patients and their impact on adherence to prescribed treatment regimens
- Capacity to work with family members and friends of patients in communicating the nature of health conditions and recommended treatments

ABILITIES

- Ability to communicate accurate information on behalf of ethnic minority patients and their community to health plans
- Ability to discuss racial and ethnic differences and issues openly, and to respond to culturally-based cues
- Ability to assess the meaning ethnicity has for individual patients
- Ability to interpret the implications of symptoms as they are expressed by individuals from different cultures
- Ability to work effectively with an interpreter to interview patients and provide health care
- Ability to evaluate new techniques, research, and knowledge regarding their applicability in working with ethnic minorities
- Ability to secure an appropriate level of adherence and/or cooperation with prescribed treatment regimens

APPENDIX 2

PATIENT SATISFACTION SURVEY: INSTRUMENT USED IN PILOT SURVEY

1. WHAT HEALTH PLAN ARE YOU A MEMBER OF? _____

2. HOW LONG HAVE YOU BEEN A MEMBER OF THIS PLAN?

_____ (MONTHS) _____ (YEARS)

3. HOW WOULD YOU DESCRIBE YOUR HEALTH TODAY? (PLEASE CIRCLE THE BEST RESPONSE)

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1	2	3	4	5

4. HOW WOULD YOU DESCRIBE YOUR HEALTH IN GENERAL OVER THE LAST FEW YEARS? (PLEASE CIRCLE THE BEST RESPONSE)

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1	2	3	4	5

5. SINCE YOU HAVE BEEN A MEMBER OF THIS HEALTH PLAN, HAVE YOU OR A MEMBER OF YOUR FAMILY USED MEDICAL SERVICES COVERED BY THE PLAN?

YES	NO
1	0

6. WHAT LANGUAGE DO YOU SPEAK MOST OFTEN AT HOME? _____

7. HOW WELL CAN YOU COMMUNICATE WITH YOUR DOCTOR IN ENGLISH?

CANNOT USE IT AT ALL	CAN USE IT VERY LITTLE	CAN USE IT SOMEWHAT	CAN USE IT WELL/FLUENTLY
1	2	3	4

IF YOU CAN USE ENGLISH FLUENTLY WHEN TALKING TO YOUR DOCTOR AND FEEL THAT YOU NEED NO TRANSLATOR HELP WHEN TALKING TO HIM OR HER, PLEASE SKIP TO QUESTION 16. IF YOU CAN USE ENGLISH VERY LITTLE OR NOT AT ALL WHEN TALKING TO YOUR DOCTOR, OR FEEL THAT YOU NEED TRANSLATOR HELP WHEN TALKING TO HIM OR HER, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

8. HOW OFTEN IS AN INTERPRETER PRESENT DURING YOUR OFFICE VISITS?

NEVER	SOMETIMES	FREQUENTLY	ALWAYS	DOCTOR SPEAKS MY LANGUAGE
1	2	3	4	5

9. WHO USUALLY INTERPRETS DURING YOUR OFFICE VISITS? (PLEASE CIRCLE ALL THAT APPLY)

- 1 - Son or daughter
- 2 - Other family member
- 3 - Friend
- 4 - Doctor or Nurse
- 5 - Professional translator
- 6 - Other employee of Health Plan
- 7 - Social worker
- 8 - No translator is needed
- 9 - Other (Please specify): _____

10. IF YOUR PRIMARY LANGUAGE IS OTHER THAN ENGLISH, WHICH OF THE FOLLOWING SERVICES DOES YOUR HEALTH PLAN OFFER IN YOUR PRIMARY LANGUAGE? (PLEASE CIRCLE ALL THAT APPLY)

- 1 - Health plan forms and brochures describing your benefits
- 2 - Answers by phone or in person to questions about plan benefits and procedures
- 3 - Telephone access to doctors 24 hours a day in case of urgent need
- 4 - Making appointments with your doctor
- 5 - Assistance getting authorization to see a specialist
- 6 - Identification of doctors who speak your language and/or understand your culture
- 7 - Health education and health prevention programs in your community
- 8 - Handling complaints about your care or treatment by the health plan
- 9 - On-going updates on plan information
- 10 - Interpreter or bilingual staff in the emergency room
- 11 - Interpreter or bilingual staff in the laboratory
- 12 - Interpreter or bilingual staff in X-ray
- 13 - Interpreter or bilingual staff in EKG
- 14 - Interpreter for visits to authorized non-Plan providers
- 15 - Any other services you appreciate (Please specify): _____

11. HOW SATISFIED ARE YOU WITH THE LANGUAGE INTERPRETING YOU RECEIVE UNDER YOUR HEALTH PLAN.

VERY SATISFIED	SATISFIED	NO OPINION	DISSATISFIED	VERY DISSATISFIED	NOT APPLICABLE
1	2	3	4	5	6

12. HOW UNDERSTANDABLE ARE THE WRITTEN COMMUNICATIONS YOU RECEIVE FROM YOUR HEALTH PLAN.

VERY UNDERSTANDABLE	UNDERSTANDABLE	NO OPINION	NOT UNDERSTANDABLE	TOTALLY NOT UNDERSTANDABLE	NOT APPLICABLE
1	2	3	4	5	6

13. HOW LONG DO YOU FEEL IS A REASONABLE TIME TO WAIT TO SEE A DOCTOR WHEN YOU HAVE AN URGENT CONDITION?

____ HOURS ____ DAYS

14. HAVE YOU EVER HAD TO WAIT MORE THAN 2 DAYS TO SEE A PLAN PHYSICIAN FOR ATTENTION TO AN URGENT CONDITION DUE TO THE UNAVAILABILITY OF A PLAN PROVIDED INTERPRETER?

YES NO
1 0

15. WHETHER OR NOT YOU EVER HAD TO WAIT MORE THAN 2 DAYS, HOW LONG ON THE AVERAGE DO YOU HAVE TO WAIT TO SEE PLAN PHYSICIANS FOR URGENT CONDITIONS IN VISITS INVOLVING PLAN PROVIDED INTERPRETER SERVICES?

ALMOST NO TIME	A FEW HOURS	A FEW DAYS	A FEW WEEKS	A FEW MONTHS
0	1	2	3	4

16. WHETHER OR NOT YOU EVER HAD TO WAIT MORE THAN 2 DAYS, HOW LONG ON THE AVERAGE DO YOU HAVE TO WAIT TO SEE PLAN PHYSICIANS FOR URGENT CONDITIONS IN VISITS NOT INVOLVING PLAN PROVIDED INTERPRETER SERVICES?

ALMOST NO TIME	A FEW HOURS	A FEW DAYS	A FEW WEEKS	A FEW MONTHS
0	1	2	3	4

17. HOW SATISFIED ARE YOU WITH THE LENGTH OF TIME YOU HAD TO SPEND WAITING FOR MEDICAL ATTENTION TO AN URGENT CONDITION DUE TO THE UNAVAILABILITY OF THE INTERPRETER SERVICES YOU NEEDED?

VERY SATISFIED	SATISFIED	NO OPINION	DISSATISFIED	VERY DISSATISFIED	NOT APPLICABLE
1	2	3	4	5	6

18. HAVE YOU EVER CALLED YOUR DOCTOR IN ORDER TO DISCUSS YOUR OR A MEMBER OF YOUR FAMILY'S HEALTH?

YES NO
1 0

19. IF YOU HAVE CALLED YOUR DOCTOR FOR SUCH A DISCUSSION, WERE YOU ABLE TO COMMUNICATE WITH YOUR DOCTOR IN YOUR NATIVE LANGUAGE?

YES	NO	NEVER TRIED TO USE IT
1	0	2

20. IF YOU HAVE NEVER CALLED YOUR DOCTOR TO DISCUSS YOUR OR A MEMBER OF YOUR FAMILY'S HEALTH, DO YOU KNOW HOW TO CALL YOUR DOCTOR FOR SUCH A DISCUSSION?

YES NO
1 0

21. DID YOUR DOCTOR GIVE YOU AN OPPORTUNITY TO PROVIDE HIM/HER WITH ENOUGH INFORMATION ABOUT YOUR MEDICAL NEEDS AND/OR SYMPTOMS?

YES
1

NO
0

22. IF NO, IS THIS BECAUSE ONE OR MORE OF THE FOLLOWING REASONS APPLIES TO YOU? (PLEASE CIRCLE ALL REASONS THAT APPLY TO YOU OR YOUR FAMILY)

- 1 - My doctor rushed me
- 2 - My doctor never asked the right question
- 3 - I was fearful of being embarrassed
- 4 - I didn't have much confidence in my doctor
- 5 - I was fearful of hearing bad news from my doctor
- 6 - I had difficulty communicating with my doctor in English
- 7 - My family doctor didn't pay attention to me
- 8 - My specialist doctor didn't pay attention to me
- 9 - Other reason (Please specify) _____

23. HOW WELL DO YOU UNDERSTAND YOUR MEDICAL CONDITION BASED ON WHAT YOUR DOCTOR TOLD YOU?

Fully
1

Somewhat
2

Hardly
3

Not at all
4

24. IF YOU FEEL THAT YOU DO NOT FULLY UNDERSTAND YOUR MEDICAL CONDITION, IS THIS BECAUSE OF ONE OR MORE OF THE FOLLOWING REASONS? (PLEASE CIRCLE ALL REASONS THAT APPLY TO YOU OR YOUR FAMILY)

- 1 - My doctor rushed me
- 2 - My doctor never asked whether I understood
- 3 - I didn't feel comfortable enough with doctor as a person
- 4 - I was fearful of hearing bad news from my doctor
- 5 - I had difficulty communicating with my doctor in English
- 6 - My family doctor didn't pay attention to me
- 7 - My specialist doctor didn't pay attention to me
- 8 - Other reason (Please specify) _____

25. PLEASE TELL US ALL OF THE DRUGS WHICH YOUR PLAN DOCTOR HAS PRESCRIBED NOW OR IN THE LAST TWO MONTHS FOR YOU TO TAKE:

NAME

DRUG 1: _____
DRUG 2: _____
DRUG 3: _____
DRUG 4: _____
DON'T KNOW: _____

26. WHICH CONDITION WAS EACH DRUG PRESCRIBED TO TREAT?

	CONDITION
DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DON'T KNOW:	_____

27. HOW OFTEN DID THE DOCTOR TELL YOU TO TAKE EACH DRUG?

	TIMES/DAY	FOR SYMPTOMS	DON'T KNOW
DRUG 1:	_____	_____	_____
DRUG 2:	_____	_____	_____
DRUG 3:	_____	_____	_____
DRUG 4:	_____	_____	_____
DON'T KNOW:	_____	_____	_____

28. ARE THE INSTRUCTIONS FOR USING THE DRUGS PRESCRIBED FOR YOU WHICH ARE WRITTEN ON THE LABELS OF THE PILL BOTTLES UNDERSTANDABLE?

ALWAYS	SOMETIMES	NEVER
2	1	0

29. ARE THE INSTRUCTIONS FOR USING THE DRUGS PRESCRIBED FOR YOU WHICH ARE ON THE LABELS OF THE PILL BOTTLES WRITTEN IN YOUR NATIVE LANGUAGE?

ALWAYS	SOMETIMES	NEVER
2	1	0

30. DOES THE PHARMACIST EXPLAIN THE INSTRUCTIONS FOR TAKING PRESCRIPTIONS TO YOU IN YOUR NATIVE LANGUAGE?

ALWAYS	SOMETIMES	NEVER
2	1	0

31. DO MEMBERS OF YOUR FAMILY OR FRIENDS PLAY A ROLE IN YOUR MAKING HEALTH DECISIONS?

ALWAYS	SOMETIMES	ONLY FOR SERIOUS CONDITIONS	NEVER
3	2	1	0

32. DOES YOUR DOCTOR ASK YOU WHETHER YOU ARE GETTING MEDICAL ADVICE FROM FAMILY OR FRIENDS?

ALWAYS	SOMETIMES	NEVER
2	1	0

33. IF YOU HAVE TOLD YOUR DOCTOR THAT YOUR FAMILY OR FRIENDS PLAY A ROLE IN YOUR MAKING HEALTH DECISIONS, DOES HE OR SHE MAKE AN EFFORT TO COMMUNICATE WITH THAT PERSON OR PERSONS?

ALWAYS SOMETIMES NEVER
2 1 0

34. HOW SATISFIED WERE YOU WITH YOUR DOCTOR'S EXPLANATION OF YOUR MEDICAL TREATMENT(S)?

VERY NO VERY HE NEVER
SATISFIED OPINION DISSATISFIED TRIED
1 3 5 6

35. HOW OFTEN DO YOU FOLLOW THE TREATMENTS PRESCRIBED BY YOUR DOCTOR(S)?

ALWAYS SOMETIMES NEVER
2 1 0

36. IF YOU DO NOT ALWAYS FOLLOW THE PRESCRIBED TREATMENTS, WHY DON'T YOU? (PLEASE CIRCLE ALL REASONS THAT APPLY TO YOU OR YOUR FAMILY)

- 1 - The instructions are not in my native language
- 2 - The treatment is too expensive
- 3 - There were side effects of the treatment
- 4 - I had no confidence in the doctor's diagnosis
- 5 - I had no confidence the treatment would improve my condition
- 6 - The duration of the treatment was too long
- 7 - The doctor's recommendations were not personally appropriate for me
- 8 - The doctor's recommendations could cause a conflict with my traditional treatments
- 9 - Other reasons (Please list) _____

37. DID YOUR DOCTOR GIVE YOU SUFFICIENT INFORMATION REGARDING ANY SIDE EFFECTS OF YOUR MEDICATIONS?

YES NO NO MEDICATIONS
1 0 WERE PRESCRIBED
2

38. HAVE YOU USED ANY OF THE FOLLOWING SOURCES OF CARE OUTSIDE YOUR HEALTH PLAN WITHOUT BEING REFERRED TO THEM BY YOUR PHYSICIAN OR HEALTH PLAN?

- 1 - Community health clinic (other than those run by your health plan)
- 2 - Herbalist
- 3 - Traditional practitioner (for example Chinese practitioner, curandero, etc.)
- 4 - Chiropractor
- 5 - Acupuncturist or other related health professional
- 6 - Private physician outside my usual health plan
- 7 - Public Health Outpatient clinic
- 8 - Hospital emergency room
- 9 - Other (Please specify): _____

39. IF YES, WHY DID YOU CHOOSE THIS SOURCE OF CARE? (PLEASE CIRCLE ALL THAT APPLY)

- 1 - They understand my illness better
- 2 - They speak my language
- 3 - Their recommendations are more acceptable
- 4 - I was frustrated by not seeing any improvement in my health
- 5 - I couldn't communicate with my doctor
- 6 - My doctor didn't provide me treatment that made me better
- 7 - My doctor rushed me
- 8 - I didn't like the side effects of my doctor's treatment
- 9 - I was frustrated that by my difficulties getting a referral to a specialist
- 10 - It was difficult to make an appointment with my doctor due to language barriers
- 11 - A friend or family member had successful treatment for a similar condition
- 12 - My doctor's treatment process was too slow
- 13 - The Plan doctor does not understand the distinct ethnic elements in my body's functioning
- 14 - Other (Please specify): _____

40. IF YOU USED ANY SUCH ALTERNATIVE SOURCES OF CARE, DID YOU SHARE THIS INFORMATION WITH YOUR DOCTOR?

YES	NO
1	0

41. IF YOU USED ALTERNATIVE SOURCES OF CARE BUT YOU DID NOT SHARE THIS INFORMATION WITH YOUR DOCTOR, WHY DIDN'T YOU?

42. OVERALL, HOW WOULD YOU SAY YOU WERE TREATED BY YOUR DOCTOR? (PLEASE PLACE YOUR ANSWERS ON THE FOLLOWING CONTINUUM BY CIRCLING A NUMBER)

INATTENTIVE	SOMEWHAT ATTENTIVE	ATTENTIVE	VERY ATTENTIVE
1	2	3	4

DISRESPECTFUL	SOMEWHAT DISRESPECTFUL	RESPECTFUL	VERY RESPECTFUL
1	2	3	4

43. OVERALL, HOW SATISFIED ARE YOU WITH THE QUALITY OF CARE YOU RECEIVE UNDER YOUR CURRENT HEALTH PLAN?

VERY DISSATISFIED	DISSATISFIED	SATISFIED	VERY SATISFIED
1	2	3	4

44. WHAT ARE YOUR HEALTH PLAN'S LIMITATIONS? (PLEASE CIRCLE ALL REASONS THAT APPLY TO YOU AND YOUR FAMILY)

- 1 - Inadequate coverage
 - 2 - Restrictions on changing doctors
 - 3 - Requirement to get a referral before seeing a specialist
 - 4 - Lack of interpreter services
 - 5 - Health plan materials are not in my native language
 - 6 - Difficulty getting appointments with doctors due to language barriers
 - 7 - The person(s) with whom you make appointments does not speak your native language
 - 8 - The premiums are too high
 - 9 - The Plan doesn't have enough specialists
 - 10- Are there any other limitations? (please specify):
-
-

45. HOW DO YOU THINK YOUR HEALTH PLAN CAN IMPROVE THE QUALITY OF ITS HEALTH CARE SERVICES AND BETTER SERVE YOUR NEEDS?

APPENDIX 3

PROVIDER SELF-ASSESSMENT SURVEY: INSTRUMENT USED IN PILOT SURVEY

1. Some specific diseases are more common in 1 particular ethnic or racial group compared to another. Assign these conditions to the groups in which they are more common by drawing a line connecting the disease and the group.

Disease	Sub-population
a. G-6PD deficiency	a. African-Americans
b. Intestinal parasitism	b. Mexican-Americans
c. Nasopharyngeal neoplasms	c. Chinese-Americans
d. Cervical cancer	
e. Thalassemia	
f. Diabetes mellitus	
g. Hypertension	
h. Sickle cell anemia	

2. To which ethnic or racial group do most of your limited non-English-speaking patients belong?
-

3. Which of the following types of patients do you find most challenging to care for?

- a. English speaking patients with symptomatic acute conditions

Very Easy	Easy	No opinion	Difficult	Very Difficult
1	2	3	4	5

- b. Non-English speaking patients with symptomatic acute conditions

Very Easy	Easy	No opinion	Difficult	Very Difficult
1	2	3	4	5

- c. English speaking patients with symptomatic chronic conditions

Very Easy	Easy	No opinion	Difficult	Very Difficult
1	2	3	4	5

d. Non-English speaking patients with symptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

e. English speaking patients with asymptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

f. Non-English speaking patients with asymptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

4. Primary responsibility for handling the issues involved in ensuring adequate care for non-English speaking patients rests the following groups?

a. Clinical staff only (e.g., nurses, physicians, other clinical staff)

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
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b. Health plan staff and office personnel only (e.g., administrators, admission staff, receptionists, interpreters)

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
---------------------	------------	-----------------	---------------	------------------------

c. Both clinical and health plan staff

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
---------------------	------------	-----------------	---------------	------------------------

5. Non-English speaking patients are just as likely as English speaking patients to ask you questions regarding their care.

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
------------------------	------------	-----------------	---------------	---------------------------

6. How do you test the quality of the interpretation when using an interpreter with a non-English speaking patient?

- a. By asking the patient multiple questions to derive a single piece of information regarding their health

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

- b. By asking the interpreter for their credentials

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

- c. By insisting that an English speaking member of the patient's family be present

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

- d. By speaking directly to the patient slowly and simply in English

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
----------------	-----------	-----------------	----------------	---------------------

7. On the average, how frequently do you meet with people who interpret for you to discuss communications with your patients?

Daily 1	Weekly 2	Monthly 3	Occasionally 4	Never 5
------------	-------------	--------------	-------------------	------------

8. Where available, family members, such as a patient's children, should be utilized to ensure more candid responses to the provider's questions

Always	Usually	Sometimes	Occasionally	Never
1	2	3	4	5

9. Where a provider's knowledge of the patient's language is limited, he or she should avoid trying to converse with the non-English speaking patient

Yes	No
1	0

10. When faced with a somatizing limited or non-English speaking patient, the doctor should automatically refer the patient to mental health providers for therapy.

Yes	No
1	0

11. How common is it for non-English speaking ethnically diverse patients to mix traditional treatments with the Western interventions physicians have prescribed for them?

Very Common	Common	Infrequently	Rarely	Never
1	2	3	4	5

12. Do you feel that those of your patients who mix traditional treatments with Western medications should be free to continue to use traditional remedies as long as those traditional remedies are not harmful?

Always	Usually	Sometimes	Occasionally	Never
1	2	3	4	5

13. If your patient is found to be using such non-harmful traditional treatments, how would you as the attending physician react?

Reprimand or discourage use	Ignore	Acknowledge/ observe closely	Encourage use
1	2	3	4

14. Non-English speaking patients are just as likely as English speaking patients to understand and adhere to treatment regimens when they suffer from diseases at an asymptomatic stage

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
------------------------	------------	-----------------	---------------	---------------------------

15. When prescribing medications for limited English speaking patients from a culturally diverse ethnic/racial group, it is often advantageous to prescribe smaller quantities of the medication per prescription in order to allow more frequent monitoring of their compliance with the treatment.

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
------------------------	------------	-----------------	---------------	---------------------------

16. A provider should anticipate similar medication reactions when ordering prescriptions for one's non-English speaking ethnically diverse patients as compared with one's English speaking patients assuming that all other things are equal (e.g., age, weight)

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
------------------------	------------	-----------------	---------------	---------------------------

17. Non-English speaking patients share similar expectations as do English speaking patients regarding the immediacy of treatment and duration of treatment prescribed by their physician

Strongly Agree 1	Agree 2	No Opinion 3	Disagree 4	Strongly Disagree 5
------------------------	------------	-----------------	---------------	---------------------------

18. When a non-English speaking patient fails to adhere to your prescribed regimen for his/ her chronic health condition, please rate the effectiveness of each of the following approaches:

- a. Avoid direct orders when communicating with patients (e.g., say to the patient "I want you to help me, so I can help you")

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- b. Rely on patient deference for you as a physician

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- c. Tell the patient that it is for the sake not only of themselves but their family

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- d. Involve other family members in the office visit

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- e. Where possible use terms drawn from the patient's culture

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- f. Have patients bring all medication bottles from current prescriptions to the visit

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- g. Have patients bring all traditional remedies to the visit

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- h. Use multiple communication methods in addition to speaking (e.g., drawing, written instructions, pamphlets, tapes or other audiovisual materials)

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

APPENDIX 4

PROVIDER BACKGROUND INFORMATION

NAME: _____

SPECIALTY/AREA OF MEDICAL TRAINING: _____

1. WHAT IS YOUR TYPE OF PRACTICE
PRIVATE OFFICE(SOLO)
PRIVATE GROUP
COMMUNITY CLINIC
HMO
IPA
2. WHAT LANGUAGES DO YOU SPEAK? _____
3. CAN YOU TAKE A MEDICAL HISTORY IN A LANGUAGE OTHER THAN ENGLISH?

YES	NO
1	0
4. IF YES, WHAT LANGUAGES? _____
5. WHAT IS YOUR RACIAL OR ETHNIC BACKGROUND? _____
6. IN WHICH COUNTRY DID YOU GO TO MEDICAL SCHOOL? _____
7. WHAT YEAR DID YOU GRADUATE? 19__
8. HAVE YOU PRACTICED MEDICINE OUTSIDE THE UNITED STATES?

YES	NO
1	0
9. HOW LONG HAVE YOU PRACTICED OUTSIDE THE UNITED STATES?
____ YEARS ____ (NEVER)
10. HAVE YOU HAD IN DEPTH EXPOSURE TO AN ETHNIC NON-ENGLISH SPEAKING POPULATION IN THE UNITED STATES?

NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
0	1	2	3	4

11. IF YES, WHICH ONES? _____

12. IDENTIFY THE ETHNIC BACKGROUND OF YOUR CURRENT PATIENTS AND ESTIMATE THE PROPORTIONS OF YOUR PATIENTS FROM EACH OF THESE ETHNIC GROUPS:

GROUP 1 ID :	_____	_____	% OF TOTAL PATIENTS
GROUP 2 ID :	_____	_____	% OF TOTAL PATIENTS
GROUP 3 ID :	_____	_____	% OF TOTAL PATIENTS
GROUP 4 ID :	_____	_____	% OF TOTAL PATIENTS

13. IN EACH OF THE FOLLOWING STAGES OF YOUR DEVELOPMENT, HOW MUCH EXPOSURE HAVE YOU HAD TO ETHNIC NON-ENGLISH SPEAKING PEOPLE?

A. GROWING UP:

NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
0	1	2	3	4

B. DURING YOUR UNDERGRADUATE OR GRADUATE EDUCATION

NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
0	1	2	3	4

C. DURING YOUR INTERNSHIP OR RESIDENCY

NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
0	1	2	3	4

D. IN YOUR MEDICAL PRACTICE

NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
0	1	2	3	4

(1-9-95)

APPENDIX 5

PATIENT SATISFACTION SURVEY: INCLUDING SUGGESTED MODIFICATIONS

1. WHAT HEALTH PLAN ARE YOU A MEMBER OF? _____
2. HOW LONG HAVE YOU BEEN A MEMBER OF THIS PLAN?
_____(MONTHS) _____(YEARS)
3. HOW WOULD YOU DESCRIBE YOUR HEALTH TODAY? (PLEASE CIRCLE THE BEST RESPONSE)

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1	2	3	4	5
4. HOW WOULD YOU DESCRIBE YOUR HEALTH IN GENERAL OVER THE LAST FEW YEARS? (PLEASE CIRCLE THE BEST RESPONSE)

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1	2	3	4	5
5. SINCE YOU HAVE BEEN A MEMBER OF THIS HEALTH PLAN, HAVE YOU OR A MEMBER OF YOUR FAMILY USED MEDICAL SERVICES COVERED BY THE PLAN?

YES	NO
1	0
6. WHAT LANGUAGE DO YOU SPEAK MOST OFTEN AT HOME? _____
7. HOW DO YOU USUALLY COMMUNICATE WHEN RECEIVING MEDICAL CARE?
 - 1 - My doctor and I talk comfortably in English
 - 2 - I speak with my doctor in my native language
 - 3 - I speak with a member of my doctor's staff in my native language
 - 4 - I use an interpreter
 - 5 - I use an adult member of my family or a friend
 - 6 - I use a child to interpret

IF YOU CAN USE ENGLISH FLUENTLY WHEN TALKING TO YOUR DOCTOR AND FEEL THAT YOU NEED NO TRANSLATOR HELP WHEN TALKING TO HIM OR HER, PLEASE SKIP TO QUESTION 17. IF YOU CAN USE ENGLISH VERY LITTLE OR NOT AT ALL WHEN TALKING TO YOUR DOCTOR, OR FEEL THAT YOU NEED TRANSLATOR HELP WHEN TALKING TO HIM OR HER, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

8. HOW OFTEN IS AN INTERPRETER PRESENT DURING YOUR OFFICE VISITS?

NEVER	SOMETIMES	FREQUENTLY	ALWAYS	DOCTOR SPEAKS MY LANGUAGE
1	2	3	4	5

9. WHO USUALLY INTERPRETS DURING YOUR OFFICE VISITS? (PLEASE CIRCLE ALL THAT APPLY)

- 1 - Son or daughter
- 2 - Other family member
- 3 - Friend
- 4 - Doctor or Nurse
- 5 - Professional translator
- 6 - Other employee of Health Plan
- 7 - Social worker
- 8 - No translator is needed
- 9 - Other (Please specify): _____

10. IF YOUR PRIMARY LANGUAGE IS OTHER THAN ENGLISH, WHICH OF THE FOLLOWING SERVICES DOES YOUR HEALTH PLAN OFFER IN YOUR PRIMARY LANGUAGE? (PLEASE CIRCLE ALL THAT APPLY)

- 1 - Health plan forms and brochures describing your benefits
- 2 - Answers by phone or in person to questions about plan benefits and procedures
- 3 - Telephone access to doctors 24 hours a day in case of urgent need
- 4 - Making appointments with your doctor
- 5 - Assistance getting authorization to see a specialist
- 6 - Identification of doctors who speak your language and/or understand your culture
- 7 - Health education and health prevention programs in your community
- 8 - Handling complaints about your care or treatment by the health plan
- 9 - On-going updates on plan information
- 10 - Interpreter or bilingual staff in the emergency room
- 11 - Interpreter or bilingual staff in the laboratory
- 12 - Interpreter or bilingual staff in X-ray
- 13 - Interpreter or bilingual staff in EKG
- 14 - Interpreter for visits to authorized non-Plan providers
- 15 - Any other services you appreciate (Please specify): _____

11. HOW UNDERSTANDABLE ARE THE WRITTEN COMMUNICATIONS YOU RECEIVE FROM YOUR HEALTH PLAN.

VERY UNDERSTAND- ABLE 1	UNDERSTAND- ABLE 2	NO OPINION 3	NOT UNDERSTAND- ABLE 4	TOTALLY NOT UNDERSTAND- ABLE 5	NOT APPLICABLE 6
----------------------------------	--------------------------	--------------------	---------------------------------	---	------------------------

12. HOW SATISFIED ARE YOU WITH THE LANGUAGE INTERPRETING YOU RECEIVE UNDER YOUR HEALTH PLAN.

VERY SATISFIED 1	SATISFIED 2	NO OPINION 3	DISSATISFIED 4	VERY DISSATISFIED 5	NOT APPLICABLE 6
------------------------	----------------	--------------------	-------------------	---------------------------	------------------------

13. HAVE YOU EVER WANTED TO ASK YOUR PLAN DOCTOR A QUESTION REGARDING EITHER YOUR CONDITION OR ABOUT THEIR INSTRUCTIONS REGARDING THERAPY, BUT NOT ASKED THE QUESTION DUE TO YOUR CONCERNS ABOUT COMMUNICATION DIFFICULTIES RESULTING FROM LANGUAGE DIFFERENCES?

YES 1	NO 0
----------	---------

14. HAVE YOU EVER HAD TO WAIT MORE THAN 2 DAYS TO SEE A PLAN PHYSICIAN FOR ATTENTION TO A CONDITION WHICH YOU FELT REQUIRED IMMEDIATE ATTENTION DUE TO THE UNAVAILABILITY OF A PLAN PROVIDED INTERPRETER?

YES 1	NO 0
----------	---------

15. WHETHER OR NOT YOU EVER HAD TO WAIT MORE THAN 2 DAYS, HOW LONG ON THE AVERAGE DO YOU HAVE TO WAIT TO SEE PLAN PHYSICIANS FOR A CONDITION WHICH YOU FELT REQUIRED IMMEDIATE ATTENTION IN VISITS INVOLVING PLAN PROVIDED INTERPRETER SERVICES?

ALMOST NO TIME 0	A FEW HOURS 1	A FEW DAYS 2	A FEW WEEKS 3	A FEW MONTHS 4
------------------------	---------------------	--------------------	---------------------	----------------------

16. WHETHER OR NOT YOU EVER HAD TO WAIT MORE THAN 2 DAYS, HOW LONG ON THE AVERAGE DO YOU HAVE TO WAIT TO SEE PLAN PHYSICIANS FOR A CONDITION WHICH YOU FELT REQUIRED IMMEDIATE ATTENTION IN VISITS NOT INVOLVING PLAN PROVIDED INTERPRETER SERVICES?

ALMOST NO TIME 0	A FEW HOURS 1	A FEW DAYS 2	A FEW WEEKS 3	A FEW MONTHS 4
------------------------	---------------------	--------------------	---------------------	----------------------

17. HOW SATISFIED ARE YOU WITH THE LENGTH OF TIME YOU HAD TO SPEND WAITING FOR MEDICAL ATTENTION TO CONDITIONS WHICH YOU FELT REQUIRED IMMEDIATE ATTENTION DUE TO THE UNAVAILABILITY OF THE INTERPRETER SERVICES YOU NEEDED?

VERY SATISFIED	SATISFIED	NO OPINION	DISSATISFIED	VERY DISSATISFIED	NOT APPLICABLE
1	2	3	4	5	6

18. HOW LONG DO YOU FEEL IS A REASONABLE TIME TO WAIT TO SEE A DOCTOR WHEN YOU HAVE AN A CONDITION WHICH YOU FEEL REQUIRES IMMEDIATE ATTENTION?

_____ HOURS _____ DAYS

19. HAVE YOU EVER CALLED YOUR DOCTOR IN ORDER TO DISCUSS YOUR OR A MEMBER OF YOUR FAMILY'S HEALTH?

YES	NO
1	0

20. IF YOU HAVE CALLED YOUR DOCTOR FOR SUCH A DISCUSSION, WERE YOU ABLE TO COMMUNICATE WITH YOUR DOCTOR IN YOUR NATIVE LANGUAGE?

YES	NO	NEVER TRIED TO USE IT
1	0	2

21. IF YOU HAVE NEVER CALLED YOUR DOCTOR TO DISCUSS YOUR OR A MEMBER OF YOUR FAMILY'S HEALTH, WHY DIDN'T YOU CALL HIM OR HER? (PLEASE CHECK ALL THAT APPLY)

- 1 - I was never sick enough
- 2 - I didn't know how to call my doctor
- 3 - My doctor actively discouraged my calling him or her
- 4 - I reached only an answering machine when I tried to call
- 5 - My doctor and I spoke different languages
- 6 - I did not have access to a telephone to make a call
- 7 - I did not have access to a telephone to receive a return call from my doctor

22. DID YOUR DOCTOR GIVE YOU AN OPPORTUNITY TO PROVIDE HIM/HER WITH ENOUGH INFORMATION ABOUT YOUR MEDICAL NEEDS AND/OR SYMPTOMS?

YES	NO
1	0

23. HOW OFTEN DOES YOUR DOCTOR ASK YOU THE SAME QUESTION OR GIVE YOU THE SAME INSTRUCTION SEVERAL TIMES IN DIFFERENT WAYS?

ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
4	3	2	1	0

24. WHEN YOU ARE DISCUSSING SERIOUS CONDITIONS OR THERAPIES, HOW OFTEN DOES YOUR DOCTOR ASK YOU TO REPEAT THE STATEMENT OR INSTRUCTIONS BACK TO THEM?

ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
4	3	2	1	0

25. HOW WELL DO YOU UNDERSTAND YOUR MEDICAL CONDITION BASED ON WHAT YOUR DOCTOR TOLD YOU?

FULLY	SOMEWHAT	HARDLY	NOT AT ALL
1	2	3	4

26. PLEASE TELL US ALL OF THE DRUGS WHICH YOUR PLAN DOCTOR HAS PRESCRIBED NOW OR IN THE LAST TWO MONTHS FOR YOU TO TAKE:

NAME

DRUG 1:	_____
DRUG 2:	_____
DRUG 3:	_____
DRUG 4:	_____
DON'T KNOW:	_____

27. WHICH CONDITION WAS EACH DRUG PRESCRIBED TO TREAT?

CONDITION

DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DRUG 1 CONDITION:	_____
DON'T KNOW:	_____

28. HOW OFTEN DID THE DOCTOR TELL YOU TO TAKE EACH DRUG?

	TIMES/DAY	FOR SYMPTOMS	DON'T KNOW
--	-----------	--------------	------------

DRUG 1:	_____	_____	_____
DRUG 2:	_____	_____	_____
DRUG 3:	_____	_____	_____
DRUG 4:	_____	_____	_____
DON'T KNOW:	_____	_____	_____

29. ARE THE INSTRUCTIONS FOR USING THE DRUGS PRESCRIBED FOR YOU WHICH ARE WRITTEN ON THE LABELS OF THE PILL BOTTLES UNDERSTANDABLE?

ALWAYS	SOMETIMES	NEVER
2	1	0

30. ARE THE INSTRUCTIONS FOR USING THE DRUGS PRESCRIBED FOR YOU WHICH ARE ON THE LABELS OF THE PILL BOTTLES WRITTEN IN YOUR NATIVE LANGUAGE?

ALWAYS	SOMETIMES	NEVER
2	1	0

31. IF THE INSTRUCTIONS ARE HARD TO UNDERSTAND, DOES THE PHARMACIST OR SOME OTHER HEALTH WORKER EXPLAIN THE INSTRUCTIONS FOR TAKING PRESCRIPTIONS TO YOU IN YOUR NATIVE LANGUAGE?

ALWAYS	SOMETIMES	NEVER
2	1	0

32. WHEN YOU ARE TAKING A PRESCRIPTION DRUG, HOW OFTEN DOES YOUR DOCTOR ASK YOU TO BRING IN THE PILL BOTTLES CONTAINING ALL OF THE PILLS YOU HAD NOT TAKEN YET?

ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
4	3	2	1	0

33. DO MEMBERS OF YOUR FAMILY OR FRIENDS PLAY A ROLE IN YOUR MAKING HEALTH DECISIONS?

ALWAYS	SOMETIMES	ONLY FOR SERIOUS CONDITIONS	NEVER
3	2	1	0

34. DOES YOUR DOCTOR ASK YOU ABOUT YOUR FAMILY MEMBERS' OR FRIENDS' ROLES IN YOUR HEALTH-RELATED DECISIONS AND ACTIONS?

ALWAYS	SOMETIMES	NEVER
2	1	0

35. IF YOU HAVE TOLD YOUR DOCTOR THAT YOUR FAMILY OR FRIENDS PLAY A ROLE IN YOUR HEALTH RELATED DECISIONS AND ACTIONS, HOW OFTEN DOES YOUR HE OR SHE MAKE AN EFFORT TO COMMUNICATE WITH THAT PERSON OR PERSONS?

ALWAYS	SOMETIMES	NEVER
2	1	0

36. WHEN YOU ARE DISCUSSING SERIOUS CONDITIONS OR THERAPIES, HOW OFTEN DOES YOUR DOCTOR HAVE OTHER ADULT FAMILY MEMBERS IN THE ROOM WITH YOU TAKING PART IN YOUR DISCUSSIONS?

ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
4	3	2	1	0

37. WHEN YOU ARE DISCUSSING SERIOUS CONDITIONS OR THERAPIES, HOW OFTEN DOES YOUR DOCTOR HAVE OTHER CHILD FAMILY MEMBERS IN THE ROOM WITH YOU TAKING PART IN YOUR DISCUSSIONS?

ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
4	3	2	1	0

38. HOW WELL DO YOU UNDERSTAND YOUR DOCTORS ORDERS REGARDING THE DRUGS YOU'RE SUPPOSED TO TAKE AND OTHER TREATMENTS?

FULLY	SOMEWHAT	HARDLY	NOT AT ALL	N/A-NO DRUGS PRESCRIBED
1	2	3	4	5

39. HOW OFTEN DO YOU FOLLOW THE TREATMENTS PRESCRIBED BY YOUR DOCTOR(S)?

ALWAYS	SOMETIMES	NEVER
2	1	0

40. IF YOU DO NOT ALWAYS FOLLOW THE PRESCRIBED TREATMENTS, WHY DON'T YOU? (PLEASE CIRCLE ALL REASONS THAT APPLY TO YOU OR YOUR FAMILY)

- 1 - The instructions are not in my native language
- 2 - The treatment is too expensive
- 3 - There were side effects of the treatment
- 4 - I had no confidence in the doctor's diagnosis
- 5 - I had no confidence the treatment would improve my condition
- 6 - The duration of the treatment was too long
- 7 - The doctor's recommendations were not personally appropriate for me
- 8 - The doctor's recommendations could cause a conflict with my traditional treatments
- 9 - Other reasons (Please list) _____

41. DID YOUR DOCTOR GIVE YOU SUFFICIENT INFORMATION REGARDING ANY SIDE EFFECTS OF YOUR MEDICATIONS?

YES	NO	NO MEDICATIONS WERE PRESCRIBED
1	0	2

42. HAVE YOU EVER RECEIVED CARE FROM OUTSIDE YOUR HEALTH PLAN TO WHICH YOU WERE NOT REFERRED BY A PLAN PHYSICIAN?

YES	NO
1	0

43. IF YOU ANSWERED 'YES' TO QUESTION 42, PLEASE CHECK ALL OF THE FOLLOWING SOURCES OF CARE OUTSIDE YOUR HEALTH PLAN WHICH YOU HAVE USED.?

- 1 - Community health clinic (other than those run by your health plan)
- 2 - Traditional source of care from your native culture (e.g., herbalist, curandero, etc.)
- 3 - Private physician outside my usual health plan
- 4 - Public Health Outpatient clinic
- 5 - Hospital emergency room
- 6 - Other (Please specify): _____

44. IF YOU HAD A SERIOUS CONDITION AND YOU USED SUCH ALTERNATIVE SOURCES OF CARE, DID YOU SHARE THIS INFORMATION WITH YOUR DOCTOR?

ALWAYS	USUALLY	SOMETIMES	NEVER	N/A-I NEVER HAD A SERIOUS CONDITION
3	2	1	0	9

45. IF YOU USED SUCH ALTERNATIVE SOURCES OF CARE AND SHARED THAT INFORMATION WITH YOUR DOCTOR, HOW DID THEY REACT?

Reprimanded or discouraged use	Ignored	Acknowledged/ observed closely	Encouraged use
1	2	3	4

46. IF YOU USED ALTERNATIVE SOURCES OF CARE BUT YOU DID NOT SHARE THIS INFORMATION WITH YOUR DOCTOR, WHY DIDN'T YOU?

48. OVERALL, HOW WOULD YOU SAY YOU WERE TREATED BY YOUR DOCTOR? (PLEASE PLACE YOUR ANSWERS ON THE FOLLOWING CONTINUUM BY CIRCLING A NUMBER)

INATTENTIVE	SOMEWHAT ATTENTIVE	ATTENTIVE	VERY ATTENTIVE
1	2	3	4
DISRESPECTFUL	SOMEWHAT DISRESPECTFUL	RESPECTFUL	VERY RESPECTFUL
1	2	3	4

49. OVERALL, HOW MUCH CONFIDENCE DID YOU HAVE IN YOUR DOCTOR?

NONE	SOME	A FAIR AMOUNT	LOTS	TOTAL
0	1	2	3	4

50. OVERALL, HOW SATISFIED ARE YOU WITH THE QUALITY OF CARE YOU RECEIVE UNDER YOUR CURRENT HEALTH PLAN?

VERY DISSATISFIED	DISSATISFIED	SATISFIED	VERY SATISFIED
1	2	3	4

51. WHAT ARE YOUR HEALTH PLAN'S LIMITATIONS? (PLEASE CIRCLE ALL CONCERNS THAT APPLY TO YOU AND YOUR FAMILY)

- 1 - Inadequate coverage
- 2 - Restrictions on changing doctors
- 3 - Requirement to get a referral before seeing a specialist
- 4 - Lack of interpreter services
- 5 - Health plan materials are not in my native language
- 6 - Difficulty getting appointments with doctors due to language barriers
- 7 - The person(s) with whom you make appointments does not speak your native language
- 8 - The premiums are too high
- 9 - The Plan doesn't have enough specialists
- 10- Are there any other limitations? (please specify):

52. HOW DO YOU THINK YOUR HEALTH PLAN CAN IMPROVE THE QUALITY OF ITS HEALTH CARE SERVICES AND BETTER SERVE YOUR NEEDS?

APPENDIX 6

PROVIDER SELF-ASSESSMENT SURVEY: INCLUDING SUGGESTED MODIFICATIONS

1. Some specific diseases are more common in 1 particular ethnic or racial group compared to another. Assign these conditions to the groups in which they are more common by drawing a line connecting the disease and the group.

Disease	Sub-population
a. G-6PD deficiency	a. African-Americans
b. Intestinal parasitism	b. Mexican-Americans
c. Nasopharyngeal neoplasms	c. Chinese-Americans
d. Cervical cancer	
e. Thalassemia	
f. Diabetes mellitus	
g. Hypertension	
h. Sickle cell anemia	

2. To which ethnic or racial group do most of your limited non-English-speaking patients belong?

3. Which of the following types of patients do you find most challenging to care for?

- a. English speaking patients with symptomatic acute conditions**

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
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- b. Non-English speaking patients with symptomatic acute conditions**

Very Easy	Easy	No opinion	Difficult	Very Difficult
1	2	3	4	5

- c. English speaking patients with symptomatic chronic conditions**

Very Easy	Easy	No opinion	Difficult	Very Difficult
1	2	3	4	5

d. Non-English speaking patients with symptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
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e. English speaking patients with asymptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
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f. Non-English speaking patients with asymptomatic chronic conditions

Very Easy 1	Easy 2	No opinion 3	Difficult 4	Very Difficult 5
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4. What percentage of your limited or Non-English speaking patients ask you questions regarding their care?

None 0	1%-20% 1	21%-40% 2	41%-60% 3	61%-80% 4	81%-100% 5
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5. What percentage of your limited or Non-English speaking patients want to ask you questions regarding their care but are unable to due to linguistic difficulties or other factors?

None 0	1%-20% 1	21%-40% 2	41%-60% 3	61%-80% 4	81%-100% 5
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6. Which strategies are effective tests of the quality of the interpretation when using an interpreter with a non-English speaking patient?

a. Asking the patient multiple questions via the interpreter to derive a single piece of information regarding their health

Very Effective 5	Effective 4	No opinion 3	Ineffective 2	Very ineffective 1
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b. Asking the interpreter for their credentials

Very Effective 5	Effective 4	No opinion 3	Ineffective 2	Very ineffective 1
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- c. Asking patients to repeat instructions back to the physician

Very Effective	Effective	No opinion	Ineffective	Very ineffective
5	4	3	2	1

7. Which strategies are effective in improving the quality of direct communication with a limited or non-English speaking patient?

- a. Speaking directly to the patient slowly and simply in English

Very Effective	Effective	No opinion	Ineffective	Very ineffective
5	4	3	2	1

- b. Insisting that an English speaking member of the patient's family be present

Very Effective	Effective	No opinion	Ineffective	Very ineffective
5	4	3	2	1

- c. Using a child family member to interpret where possible since the child is intimately familiar with family dynamics

Very Effective	Effective	No opinion	Ineffective	Very ineffective
5	4	3	2	1

8. On the average, how frequently do you meet with people who interpret for you to discuss communications with your patients?

Daily	Weekly	Monthly	Occasionally	Never
1	2	3	4	5

9. When faced with a somatizing limited or non-English speaking patient, the doctor should automatically refer the patient to mental health providers for therapy.

Yes	No
1	0

10. How common is it for your limited or non-English speaking, ethnically diverse patients to mix traditional treatments with the Western interventions physicians have prescribed for them?

Very Common	Common	Infrequently	Rarely	Never
1	2	3	4	5

12. Do you feel that those of your patients who mix traditional treatments with Western medications should be free to continue to use traditional remedies as long as those traditional remedies are not harmful?

Always	Usually	Sometimes	Occasionally	Never
1	2	3	4	5

13. If your patient is found to be using such non-harmful traditional treatments, how would you as the attending physician react?

Reprimand or discourage use	Ignore	Acknowledge/ observe closely	Encourage use
1	2	3	4

14. What percentage of your limited or Non-English speaking patients understand and adhere to virtually all of their prescribed treatment regimens?

None	1%-20%	21%-40%	41%-60%	61%-80%	81%-100%
0	1	2	3	4	5

15. A provider should anticipate similar medication reactions when ordering prescriptions for one's non-English speaking ethnically diverse patients as compared with one's English speaking patients assuming that all other things are equal (e.g., age, weight)

Strongly Agree	Agree	Strongly No Opinion	Disagree	Disagree
1	2	3	4	5

16. What percentage of the time do you inform your limited or Non-English speaking patients about potential side-effects of the medications which you prescribe for them?

None	1%-20%	21%-40%	41%-60%	61%-80%	81%-100%
0	1	2	3	4	5

17. Non-English speaking patients share similar expectations as do English speaking patients regarding the immediacy of treatment and duration of treatment prescribed by their physician

Strongly Agree	Agree	Strongly No Opinion	Disagree	Disagree
1	2	3	4	5

18. When giving a prescription to a non-English speaking patient, how effective are each of the following steps in maximizing patient adherence to your prescribed regimens?

a. Prescribing smaller quantities of the medication per prescription in order to allow more frequent monitoring of their compliance with the treatment.

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

b. Relying on patient deference for you as a physician

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

c. Telling the patient that they should follow your prescribed regimen not only for their own sake but also for their family's sake

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

d. Have other family members in the office when giving instructions regarding the therapy

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

e. Giving therapeutic instructions where possible using terms drawn from the patients' cultures

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

f. Having patients bring all medication bottles from current prescriptions to the visit

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

g. Having patients repeat all therapeutic instructions after you give them

Totally Ineffective	Minimally Effective	Fairly Effective	Very Effective
1	2	3	4

- h. Using multiple communication methods in addition to speaking (e.g., drawing, written instructions, pamphlets, tapes or other audiovisual materials)

Totally
Ineffective
1

Minimally
Effective
2

Fairly
Effective
3

Very
Effective
4